P.G.D.A.V. COLLEGE (Eve.)

(UNIVERSITY OF DELHI)

2743

NEHRU NAGAR, NEW DELHI - 110065

APPLICATION FORM FOR MEDICAL CLAIM

1. (i) Name and designation of the employee/pensioner:- ....

   (In BLOCK Letters) ....

   (ii) Whether married or unmarried ....

   (iii) If married whether wife/husband is employed ....

   (iv) If yes mention place of employment ....

   (In case of employed, a joint declaration duly countersigned by the employer of wife/ husband may be furnished at the time of first bill in each financial year) ....

2. Where employed — **P.G.D.A.V. COLLEGE (Eve.)** **NEHRU NAGAR, NEW DELHI 110065**

3. Pay/pension of the college employee/pensioner and Other emoluments which should be shown separately

4. Actual residential address

5. Name of the patient and his / her relationship to the University/College Employee/Pensioner. (In the case of children, state age also)

6. Place at which the patient fell ill

7. Whether member of WUS Health Centre or Not?

Acknowledgement

2743

Received a bill for Rs......................(in words)..............................

From Mr./Ms..............................

Received by:.............................. Dated:........................

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Details of the amount claimed

(I) MEDICAL ATTENDANCE:

(I) Fees for consultation, including:

(a) The name, qualification and designation of the Medical Officer consulted and the Hospital or Dispensary to which attached ....

(b) The number and dates of consultation and the fee paid for each consultation ....

....

(c) The number and dates of injection and the fee paid for each injection.

(d) Whether consultations and/or injections were had at the hospital, at the consulting room of the Medical Officer or at the residence of the patient.

(II) Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating :..

(a) The name of the hospital / laboratory where undertaken :..

(b) Whether the tests were undertaken on the advice of the Authorized Medical Attendant. If so, a certificate to that effect should be attached ....

8. TOTAL AMOUNT CLAIMED:
(a+b+c)

(a) Medicines ....

(b) Consultation ....

(c) Injection/Test fee ....

(List of medicines' cash memos to be attached)

9. LIST OF ENCLOSURES:

1...

2...

3...

4...

5...

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P.G.D.A.V. COLLEGE (Eve.)

CERTIFICATE 'A'

Certificate granted to Mr./Mrs./Miss ....

Husband/Wife/Son/Daughter of Mr./Mrs./Miss..

employed in this college.

1, Dr. ....hereby certify

(a) That I charged and received Rs ....for...
Consultations on...(dates to be given) at my consulting room/at the residence of patient.

(b) That I charged and received Rs...................................for administering.......................................
Intravenous/intra-muscular/subcutaneous injections on...............................(date to be given)
at....................................my consulting room/the residence of the patient.

(c) That the injections administered were not/were for immunizing or prophylactic purposes;

S.No.	NAME OF MEDICINES	CASH MEMO NO	DATE	PRICE
		TOTAL		

(d) That the patient is/was suffering from...and is/was under my treatment from..to.......................................

(e) That the patient is/was not given pre-natal or post-natal treatment.

(f) That the X-ray, Laboratory test, etc., for which an expenditure of Rs.........................was incurred was necessary and were undertaken on my advice at............................(name of the Hospital or laboratory).

(g) That I referred the patient to Dr...for Specialist Consultation. The necessary approval as required under rules was obtained.

(h) The patient did not require / required hospitalization.

SIGNATURE & DESIGNATION OF THE MEDICAL OFFICER
OF HOSPITAL/DISPENSARY TO WHICH ATTACHED WITH SEAL

DATED:..............................

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DECLARATION TO BE SIGNED BY THE COLLEGE EMPLOYEE/PENSIONER

(i) I hereby declare that statements in this application are true to the best of my knowledge and belief and that person for whom medical expenses were incurred is wholly dependent upon me.

(ii) Certified that my wife/husband is employed/not employed anywhere and I have not claimed the payment of this bill from any other sources.

Revenue Stamp

Entered at Page No ....

(Signature of the employee/pensioner)

Passed for Rs ....

1. Medicines :..
2. Consultation :..................................
3. Tests :..
4. Others :..

Assistant S.O.A/Cs Bursar Principal

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UNIVERSITY OF DELHI
P.G.D.A.V. COLLEGE (EVE.)

CERTIFICATE – B

Name of the Hospital ....

O.P.D. No. ....

(To be completed in the case of patients when admitted to Hospital for Treatment)

Certificate granted to Mr./Mrs./Miss ....

Wife/Son/Daughter of Mr...

Employed in ....

PART – A

(To be signed by the Officer-in-charge of the case at the Hospital)

I, Dr. .... Hereby certify

(a) That the patient was admitted to the hospital on the advice on my advice

----

(Name of Medical Officer)

(b) That the patient has been under treatment at .... Hospital and the under-mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient. The medicines are not stocked in .... Hospital for supply to private patient and do not include proprietary preparations for which other substance of equal therapeutic value are available, nor preparations which are primarily, food, toilets or disinfectants.

<u>Name of Medicines</u> <u>Price</u>

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(c) That the injections administered were not for immunizing or prophylactic or mental or dental purposes.

(d) That the patient is/was suffering from .... And is/was under treatment from .... To ....

(e) That the X-ray, Laboratory test, etc. for which an expenditure of Rs........................ was incurred, were necessary and were undertaken on my advice at .... Hospital.

(f) That I called in Dr.. for specialist consultation and that the necessary approval of the .... as required under the rules was obtained. (Name of Chief of the State)

Signature and designation of the Medical Officer-in-charge of the Case at the Hospital. ....

PART – B

I certify that patient has been under treatment of .... Hospital and that the services of a Special Burse for which an expenditure of Rs................ Was incurred vide bills and receipts attached, were essential for the recovery/ prevention of serious deterioration in the condition of the patient.

....

Signature of Medical Officer-in Charge in case at the Hospital

COUNTERSIGNED

I certify that the patient has been under treatment at .... Hospital and that the facilities provided were the minimum which were essential for the patient's treatment.

Date ....

Place......................

Medical Superintendent
Of the Hospital

N.B.:- i) Certificate not applicable should be struck off.

ii) Certificate (d) is compulsory and must be filled in by the Medical Officer in all cases.

I certify that .... Hospital is recognized by the authorities of the Government of India and the Delhi Administration for the treatment of Government Employees and their families.

Medical Superintendent

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