**APPLICATION FORM FOR REIMBURSEMENT OF MEDICAL CHARGES**

1. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of the serving/retired Federal Government Servant (Alive/Deceased).

1. Name of the patient & relationship with claimant as dependent, as specified in Rule 2(d) of the Federal Services Medical Attendance Rules, 1990\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Diagnosis of the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Ministry/Division/Department/Office of the serving/retired Govt. Servant at S. No. 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Vendor No. and PPO No. for retired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. List of Medicines with quantity/hospital bill/Laboratory and other diagnostic charges etc. for which reimbursement is claimed through this bill (format attached).

**PART –B**

Certificate by Government servant (or member of his family in case deceased Government Servant) that:-

1. This member(s) of my family for whose treatment reimbursement has been claimed is wholly dependent upon me.
2. The claim was not drawn before.
3. I shall have no objection to the recovery of any amount overpaid, if any, from my pay/pension or otherwise.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full name of the Government Servant

Or (claimant family member in case of

Decease) (IN Block LETTERS)

Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERTIFICATES BY THE AUTHORIZED MEDICAL ATTENDANT**

Certified that the medicines/drugs/hospitalization/clinical tests/examinations listed below were essential for the recovery and restoration of the patient, Mr./Mrs./Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is further certified that neither the medicines/drugs etc. nor their effective substitutes could be supplied from the hospital/dispensary.

The treatment of clinical tests/examination/consultation (listed back) were obtained in emergency, not available in the hospital, hence the patient, Mr./Mrs./Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is hereby referred to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Total Rs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Designation & official stamp |

COUNTERSIGNATURE

Hospital Authority

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation & official stamp

-:2:-

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S. No. | No. & date of bill/cash memo | Name of the Chemist | Name of Drugs/Medicines | Amount |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name of the Govt. Servant)