

VIVEKANANDA COLLEGE

(UNIVERSITY OF DELHI)

VIVEK VIHAR, DELHI - 110095

Form of Application for claiming refund of medical expenses incurred in connection with medical attendance and / or treatment of College employees and their families

N.B. Separate form should be used for each patient

1. Name and designation of the employee
(IN BLOCK LETTERS)
(i) Whether married or unmarried
(ii) If married, the place where wife / husband is employed (where applicable)
2. Where employed : VIVEKANANDA COLLEGE, VIVEK VIHAR, DELHI
3. Pay of the College employee, and any other emoluments, which should be shown separately Basic Pay Rs.
4. Pay of duty As in Col. 2
5. Actual residential address

6. Name of the Patient and his / her relationship to the college employee.
N.B. In the case of children state age also.

7. Place at which the patient fell ill

Detail of the amount claimed -

1. 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 consultations and the fee paid for each consultation.
 - (c) the number and dates of injections and the fee paid for each injection.
 - (d) Where 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 or laboratory where the tests were undertaken, and
 - (b) Whether the tests were undertaken on the advice of the authorised medical attendant. If so a certificate to that effect should be attached.
- (iii) Cost of medicines purchased from the market.

List of medicines, cash memos and the essential certificates should be attached.

9. Total amount claimed " Rs.....

Cost of Medicines	Consultation Fee	Inj. Charges	Test Charges	Other Charges

10. List of enclosures :
- | | |
|---------------------------------|----------|
| 1. Certificates 'A' / 'B' | Nos..... |
| 2. Prescription | Nos..... |
| 3. Cash Memos | Nos..... |
| 4. Non-Availability Certificate | |
| 5. | Nos..... |
| 6. | Nos..... |

Total = Nos.....

11. I hereby request you to please re-imburse the bill and credit the amount in my bank A/c as per details given below :

Name of A/c Holder	Bank Name	Account No.	IFSC Code

CERTIFICATE

- Certified that I am not a member of the W.U.S. Health Centre.
- Certified that there is no co-op. medical store within the radius of 2 kilometres from my residence.

Signature of the Employee

DECLARATION TO BE SIGNED BY THE COLLEGE EMPLOYEE

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

(PRE-RECEIPTED)

Date :

Signature of the Employee

(FOR OFFICE USE ONLY)

Entered in the Medical Register at Page No.

Dealing Assistant

Section Officer

Amount Claimed

Amount Admissible

- | | | |
|----------------------|---------|---------|
| 1. Cost of Medicines | Rs..... | Rs..... |
| 2. Consultation Fee | Rs..... | Rs..... |
| 3. Injection Charges | Rs..... | Rs..... |
| 4. Test Charges | Rs..... | Rs..... |
| 5. | Rs..... | Rs..... |
| 6. | Rs..... | Rs..... |

Total = Rs..... Rs.....

Pay Rs..... (Rupees.....)

Debitable to Reimbursement of Medical Expense a/c.

Asslt.

S.O. (A/cs)

A.O. (A/cs)

Burser

Principal

VIVEKANANDA COLLEGE

(UNIVERSITY OF DELHI)

VIVEK VIHAR, DELHI -110095

CERTIFICATE 'A'

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

wife/ husband/ son/ daughter / father of Mr./Miss/Mrs.....

employed in the **VIVEKANANDA COLLEGE**

I, Dr..... hereby certify

- (a) That I charged and received Rs..... for consultation
on.....
(date (s) to be given)
at my consulting room
at the residence of the patient
- (b) that I charged and receive Rs..... for administering.....
intra muscular injections or subcutaneous.
on
(date (s) to be given)
at my consulting room
at the residence of the patient
- (c) the injection administered were for immunising or prophylactic purposes.
were not
- (d) that the patient has been under treatment at.....

..... (Address)

.....
hospital

my consulting room and that the undermentioned 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 the (Name of the Hospital)

for supply to private patients and to not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or dis-fectants.

Name of medicines (in CAPITAL LETTERS)

Price
Rs. P.

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....
- 6.....
- 7.....
- 8.....
- 9.....
- 10.....

Total

- (e) that the patient is/ was suffering from and is / was under my treatment
from to
- (f) that the patient is / was not given pre-natal treatment.
- (g) that the X-Ray laboratory test etc, for which an expenditure of Rs..... was incurred were necessary
and were undertaken on my advice at (Name of the Hospital or Laboratory)
- (h) that I referred the patient to Dr. for specialist consultation and that the necessary
approval of the (Name of the Chief
Administrative Medical Officer of the State as required under the rules was obtained.
- (i) that the Patient did not require hospitalisation.
required

.....
Signature and Designation of the
Medical Officer and hospital/dispensary
to which attached with seal.

Date.....

N.D. : Certificate (s) not applicable should be struck off. Certificate (s) is / are compulsory and must be filled in by the Medical Officer in all cases.

VIVEKANANDA COLLEGE

(UNIVERSITY OF DELHI)

VIVEK VIHAR, DELHI - 110095

CERTIFICATE 'B'

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

wife / husband / son / daughter / father of Mr. / Miss / Mrs.....
employed in the **VIVEKANANDA COLLEGE**

PART-A

I, Dr..... hereby certify

- (a) that the patient was admitted to hospital on the advice of
on my advice

.....
(Name of the medical officer)

- (b) that the patient has been under treatment at.....
.....and that the undermentioned 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 the
..... (Name of the Hospital) for supply to private patients and
do not include proprietary preparations for which cheaper substances of equal therapeutic value are available
nor preparations which are primarily foods, toilets or disinfectants.

Name of medicines (in Capital Letters)

Price
Rs. P.

- | | |
|---------|-------|
| 1..... | ..... |
| 2..... | ..... |
| 3..... | ..... |
| 4..... | ..... |
| 5..... | ..... |
| 6..... | ..... |
| 7..... | ..... |
| 8..... | ..... |
| 9..... | ..... |
| 10..... | ..... |
| 11..... | ..... |
| 12..... | ..... |
| 13..... | ..... |
| 14..... | ..... |
| 15..... | ..... |
| 16..... | ..... |
| 17..... | ..... |
| 18..... | ..... |
| 19..... | ..... |
| 20..... | ..... |
| 21..... | ..... |
| 22..... | ..... |
| 23..... | ..... |
| 24..... | ..... |
| 25..... | ..... |

TOTAL

.....

- (c) the injections administered were for immunising or prophylactic purposes.
 were not
- (d) that the patient is / was suffering from and is / was under my 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
(Name of the Hospital or Laboratory)
- (f) that I called on Dr. for specialist consultation and that the necessary approval
 of the
 (Name of the Chief Administrative Medical Officer of the State) as required under the rules was obtained.

.....
 Signature and Designation of the
 Medical Officer-in-charge of the case at the hospital

PART-B

I certify that the patient has been under treatment at the hospital and that
 the service of the special nurses, for which an expenditure of Rs. was incurred vide
 bills and receipts attached, was essential for the recovery/prevention of serious deterioration in the condition of the
 patient.

.....
 Signature of the Medical Officer-in-charge
 of the case at the hospital

COUNTERSIGNED

Medical Superintendent

.....hospital

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

Medical Superintendent

..... hospital

Place.....

N.B. : Certificate (s) not applicable should be struck off. Certificate (s) is / are compulsory and must be filled in by the
 Medical Officer in all cases.

विवेकानन्द महाविद्यालय
VIVEKANANDA COLLEGE
(दिल्ली विश्वविद्यालय)
(University of Delhi)
विवेक विहार, दिल्ली - ११००९५
VIVEK VIHAR, DELHI - 110095

Medical Reimbursement Undertaking

I hereby give an undertaking to return any excess payment made to me by the College, in respect of medical reimbursement availed by me from the College at any point of time after verification by audit party.

Signature of the Employee

Name _____

Designation _____

Date _____

In Position

I hereby declare & certify that my son/daughter Ms. /Mr. _____ is _____ years old as on date _____ and that she / he is neither married nor employed anywhere. My son/daughter /Ms. / Mr. _____ is wholly dependent upon me.

The above information is true to the best of my knowledge and I will be held responsible for any wrong information.

Signature of the Employee

Name _____

Designation _____

Date _____

In Position

I hereby declare & certify that my parents / in laws Mr. / Mrs. _____ & _____ are _____ & _____ years old respectively and that their income is up to Rs. 9000/- plus the amount of DR. admissible on Rs. 9000/- as on date. My parents / in laws are / are not wholly dependent upon me.

The above information is true to the best of my knowledge and I will be held responsible for any wrong information.

Signature of the Employee

Name _____

Designation _____

Date _____