

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

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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
-
8. 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

1. Certified that I am not a member of the W.U.S. Health Centre.
2. 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

	<u>Amount Claimed</u>	<u>Amount Admissible</u>
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.

Asstt.

S.O. (A/cs)

A.O. (A/cs)

Bursar

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 at my consulting room
(date (s) to be given) at the residence of the patient

(b) that I charged and receive Rs..... for administering.....
intra muscular injections or subcutaneous.
on at my consulting room
(date (s) to be given) 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 deterioratio. 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.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.