FORM OF APPLICATION FOR CLAIMINGH REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDENCE AND TREATMENT OF CENTRAL GOVT. SERVANTS AND THEIR FAMILY - FOR MEDICAL ATTENDENCE / TREATMENT TAKEN BOTH FROM AND AMA AND A HOSPITAL.

1.	Name & designation of Govt. Servant		
	(i)	Whether married or unmarried	
	(ii)	If married the place/office where wife/Husband if employed. Name of the office/place in which employed.	
3.	If married he/she is not drawing medical reimbursement of fixed medical allowance or any other payment.		
4.	Office in Which employed		
5.	Pay of Govt. Servant		
6.	Name of the patient and his/her relationship to the Govt. Servant N.B.-in case of child , age of the child		
8.	Place of duty		
9.	Place at which patient fell ill.		
10.	Name of the medical officer consulted and the name of the hospital/dispensary to which he related		
11.	Residence Address		
12.	Cost of medicines purchased		
13.	Less advance		
14.	Net amount claimed		

Declaration to be signed by the Government Servant

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

Signature of Govt. official

Section :

SBI A/C No._____ PUCDA _____ Pay Code _____

OFFICE OF THE PRINCIPAL DIRECTOR GENERAL OF AUDIT (CENTRAL) PUNJAB & U.T. CHANDIGARH

EXTRACT OF MEDICAL CLAIM

1.	Name & designation of Govt. Servant and Section to which he/she belongs and pay	
2.	Residence place at which patient fell ill.	
3.	Name of the patient and his/her relation to the Govt. Servant in case of child age also.	
4.	Name of the disease and period, Name of medical attendant and treatment given in certificate 'A'	
	Name of the authorized medical attendant and hospital to which attached given certificate and for treatment	
((6.	Fee paid to authorized medical attendant and date of authorized local attendant receipt	
7.	Date of consultation	
8.	No. of injection administered with date	
9.	No. of IV Injections	

10.	Name of Chemist	Bill No. and date	Name of medicines	Amount
	TOTAL			

DECLARATION TO BE SIGNED BY THE GOPVERNMENT SERVANT

I hereby declare that particulars furnished above are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me.

_____

Full signature of the Govt. Servant

Forwarded to the O.E.II. Section for necessary action.

A.A.O. / Sr. A.O.

Scrutinized and passed for Rupees _____

A.A.O **Sr. A.O.** **Sr. D.A.G.**

PESSENTIALITY CERTIFICATES

CERTIFICATE 'A'

(To be completed in the case of patients who are not admitted to hospital for treatment)

certificate granted to Mrs./**Mr.**/Miss _____ wife/son/daughter of Mr_____ employed in the office of the Pr. Accountant General (Audit) Punjab & U.T., Chandigarh.

I, Dr_____ hereby certify--

(a) that I charged and received Rs ____ for _____ consultations on_____(dates to be given) at my consultation room/at the residence of the patient).

(b) that I charged and received Rs _____ for administering ____ intravenous/intra-muscular/subcutaneous injections on ____ (dates 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;

(d) that the patient has been under treatment at ____ hospital /my consulting room and that 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 the ____ (name of the Hospital) for supply to private patients and do not include proprietary preparati0ons for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants.

NAME OF MEDICINES	PRICE
TOTAL	

that the patient is/was suffering from _____ and is/was under my treatment from _____

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

(f) 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 and that the necessary approval of the (name of the Chief Administrative Officer of the State) as required under the rules was obtained.

(h) That the patient did not require /required hospitalization.

Date:-

Signature of AMA/
Designation of the Medical Officer and hospital/ dispensary to which attached