Motilal Nehru College
(UNIVERSITY OF DELHI)

APPLICATION FORM FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR TREATMENT OF UNIVERSITY 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) Wheter Married or Unmarried :_____

(ii) If married. The place where wife/husband of the employee is employed (where application)_____

(In case employed, Joint Declaration duly countersigned by the wife employer/husband of the child may be furnished at the Time of first bill in each financial year).

2. Where Employed : MOTILAL NEHRU COLLEGE, BENITO JUAREZ MARG, NEW DELHI-110021

3. Pay of the University / College employee, and any other emoluments, which should shown separately : B.P. _____

Other Allowances_____

Total _____

4. Place of Duty : MOTILAL NEHRU COLLEGE LAB / LIBRARY / OFFICE

5. Actual Residential Address: _____

_____

6. Name of the Patient and his / her relationship to the University / College employee
Note : in the case of children state age also.

7. Place at which the patient fell ill :_____
_____

8. Whether member of W.U.S. Health Centre or Not : _____
_____

9. **Details of the amount claimed :**

(i)

MEDICAL ATTENDANCE :

(a) The name qualification and designation of the medical officer consumed and the hospital or dispensary to which attached: ___
_____

(b) The number and date. of consultation and the fee paid for each consultation : _____

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

(d) Whether consultations and / or injections were had at the hospital in the consulting room of the medical office or at the residence of the patient_____

(ii) Charge for pathological, Bacteriological, Radiological or other similar tests undertaken during diagnosis indicating:

(a) The name of the hospital or laboratory where tests were undertaken._____

(b) and whether the tests were undertaken on the advice of the authorized medical attendant. If so, a certificate to that effect should be attached.

(iii) Cost of medicines, purchases from the market. _____

(List of medicines, Cash memos and the Essential certificates should be attached.)

II. HOSPITAL TREATMENT

Name of the Hospital: _____

Charges for hospital treatment, indication separately the charges for :

(i) Accommodation: _____

(State whether it was according to the status or pay of the employee and n cases where the accommodation is higher Than the status of the employee. A certificate should be attached to the effect that the accommodation to which he was entitled was not available).

(ii) Diet : _____

(iii) Surgical operation or medical treatment on confinement: _____

(iv) **Pathological, Bacteriological Radiological or other similar tests, indicating :**

(a) The name of the hospital or laboratory at which undertaken, and _____

(b) **Whether undertaken on the advice of the medical officer in-charge of the case at the hospital. If so, a certificate to that effect should be attached**

(v) Medicines : _____

(vi) Special Medicines : _____

(List of Medicines, Cash memos and the Essential certificates should be attached).

(vii) Ordinary nursing : _____

(viii) Special nursing i.e. nurses specially engaged for the patient. State whether they were employed on the advice of the medical officer-in-charge of the case at the hospital or at the request of the employee of patient. In the former case a certificate from the medical officer-in-charge of the case and countersigned by the Medical Superintendent of the hospital should be attached._ _____.

(ix) *Ambulance Charges : Rs. _____ From _____ To _____

(In case ambulance is not Available and a Taxi is used in lieu there of then please produce a certificate from the hospital To this effect that conveyance was essential for the patient.

(x) Any other charges, e.g. charges for electric light, fan, heater, air-conditioning, etc. State also whether the facilities referred to are a part of the facilities normally provided to all patients and no choice was left to the patient _____

Notes : 1. If the treatment was received by the employee at his/her residence, give particulars of such treatment and attach a certificate from the authorized medical attendant as required by these rules.

2. If the treatment was received at Hospital other than a Government Hospital necessary details and the certificate of the authorized medical attendant that this requisite treatment was not available in any nearest Government Hospital should be furnished.

3. All tests should be undertaken at Govt. Hospitals/Dispensaries. (in the case of O.P.D. treatment).

III. CONSULATATION WITH SPECIALIST

Fees paid to specialist or Medical Officer other than the authorized Medical attendant, indicating :

(a) The name ad designation of the Specialist or Medical Officer consulted and the hospital to which attached. _____

(b) Number and dates of consultations and the fee charged for each consultation.

(c) Whether consultation was had at the hospital, at the consulting room of the Specialist or Medical Officer at the residence of the patient.

(d) **Whether the Specialist or Medical Officer was consulted on the advice of the authorized Medical Attendant and the prior approval of the Chief Administrative Medical Officer of the State was obtained. If so, a certificate to that effect should be attached.**

10. Total amount claimed : Rs. _____

11. List of enclosures : _____

_____

DECLARATION TO BE SGNED BY THE UNIVERSITY / COLLEGE EMPLOYEE

I herby declare that statement in this application are true to the best of my knowledge and belief that the person for whom medical Expenses were incurred is residing with and wholly dependent upon me and his/her income is less than Rs. 500/- p.m. from all sources. This is to certify that there does not exist any government or Cooperative Drugs Store within the radius of 2 Kms. from my residence.

(PRE-RECEIPTED)

Dated ……..... Signature of College Employee

(1) Amount does not exceed to Rs. 500/- during the financial year.

(2) 5% empties of the used medicines as wrappers, vials, bottles are enclosed for verification and destruction.

(3) All the empties, as wrappers, vials, bottles are enclosed for verification and destruction as the amount has exceeded Rs. 1000/- During the financial year.

(4) Entry of this Medical Bill is made at page No. ……. Sr. No. …….. ..of Medical Bill Register.

Signature of the controlling authority with Office Seal

(TO BE FILLED IN BY THE ACCOUNT OFFICE)

Pay to Mr. / Mrs. / Miss …….

DEBIT ACCOUNT : Maintenance Grant Passed for Rs. ……(Rupees……)

Debit Head : Sec. 15-B/Medical Reimbursement : Paid Vide Cheque No. ……Date……...

Dealing Assistant Sr. Asstt. S.O. (Accounts) A.O. Bursar Principal

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(CERTIFICATE 'A')

Certificate granted to Mr. / Mrs. / Miss_____

Wife / Son / Daughter of Mr. _____

Employee in the MOTOLAL NEHRU COLLEGE LAB / LIBRARY / OFFICE

1. I Dr. _____hereby certify

a) that I charged Rs……for consultation of _____ at my consulting room / at the residence of patient.

b) that I charges & received Rs……..for administering _____ at any consulting room / residence of patient.

c) the injections administered were / were not for immunizing, prophylactic purpose.

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 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 & do not include proprietary preparations for, which cheaper substances of equal therapeutic value are available nor preparation which are primarily foods, toiletries or disinfectants.

NAME OF MEDICINES	NAME OF CHEMIST	CASH MEMO & DATE	PRICES

e) that the patient is / was not given prenatal or post-natal treatment._____

f) that the patient is / was suffering from _____is / was under my treatment from _____ _____to_____

g) that X- ray / Laboratory test etc. for which an expenditure of Rs. ……was incurred was necessary and were undertaken on my advice at _____

(Name of Hospital / Laboratory)

h) that I referred the patient to Dr. _____for special consultation and the necessary approval of the _____ (Name of the Chief Admn. Medical Officer) as required under the rules obtained.

i) that the patient did not require hospitalization.

Dated ……

Signature and Designation of the Medical Officer with rubber stamp Hospital / Dispensary to which attached.