APPLICATION FORM FOR REIMBURSEMENT OF MDEDICAL CHARGES IN RESPECT OF SERVING/RETIRED GOVERNEMTN SERVANT AND HIS/HER DEPENDENTS

PART-A

1. Name ______________________ Designation ______________________

BPS No.__________ of the Serving/retired Federal Government Servant, (Alive/Deceased).

2. Name of the patient ______________________ & relationship with the claimant ______________________ as dependent, as specified in rule 2(d) of the Federal Government Medical Attendance Rules, 1990.

3. Diagnosis of the patient ______________________.

4. Name of institution of the serving/retire Govt Servant at S. no.1 ______________________

______________________.

5. Vendor no. and PPO no. for retired ______________________.
(Also attached pension payment order for verification of PPO no.)

PART-B

Certificates by Govt. Servant (or member of his family in case of deceased Govt. Servant)

Certified that: -

(i) The member(s) of my family for whose treatment reimbursement has been claimed is wholly dependent upon me.

(ii) The claim was not drawn before.

(iii) I shall have no objection to the recovery of any mount overpaid, if any, from my pay/pension or otherwise.

Signature ______________________
Full name of the Govt. Servant or
(Claimant family member in case of deceased)

Dated: ______________ ______________________
(IN BLOCK LETTERS)

CERTIFICATE BY THE AUTHORISZED MEDICAL ATTENDAT

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

____

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

Signature ______________________
Designation ______________________
Dated: ______________ Official Stamp ______________________

COUNTERSIGNATURES

Departmental Controlling Authority

Signature ______________________

Designation ______________________

Official Stamp ______________________

Hospital Authority

Signature ______________________

Designation ______________________

Official Stamp ______________________

Cont …. P/2

S no.	No. & date of bill / Cash memo	Name of Chemist Shop / Hospital / Clinic/Dispensary	Name of Drugs / Medicines with Quantity/Details of Tests etc		Amount Rupees
			Name of Drugs	Quantity	

Dated: ____________________ Signature ________________________

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(FULL NAME OF THE GOVT. SERVANT)