RAM LAL ANAND COLLEGE

Benito Juarez Road, New Delhi-110021

Form for claiming refund of medical expenses incurred in connection with medical treatment and attendance of College employees and their families. (Separate form should be used for each patient)

1. (i) Name and designation of the Employee (in Block Letter) : .....

   (ii) Whether married of unmarried : .....

   (iii) if married the place where wife/husband is employed (where applicable) : .....

2. Pay of the College Employee : Basic Pay Rs. .....

3. Actual residential address of the Employee : .....

   .....

4. Name of the Patient and his/her relationship to the College employee (in case of children stage age) :

5. Place at which the patient fell ill :

6. Details of the amount claimed :-

   (i) a. Name, qualification and designation of panel medical officer consulted and the dispensary of hospital to which attached. :

   b. Number and dates of consultation and the fee paid for each consultation. :

   c. Number and dates of injections had and the fee paid for each injection. :

   d. Whether consultations and/or injections were had at the hospital. or at the consulting room of the medical officer or at the residence of the patient. :

   (ii) Charges of pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating :- :

   a. The name of the hospital or laboratory where the tests were undertaken :

   b. Whether the tests were undertaken on the advice of the authorised medical attendant. It so, a certificate to that effect should be attached. :

   (iii) Costs of medicines purchased from the market. (Prescription of medicines, cash memos and the essential certificates should be attached) : Rs. .....

7. Total amount claimed : Rs. .....

DECLARATION AND UNDERTAKING BY THE COLLEGE EMPLOYEE

I hereby declare as under :

i. That there is no government Co-operative Medical Store or Super Bazar within a radius of 2 Kms from my residence.

ii. That I am not a member of W.U.S. Health Centre.

iii. That my wife/husband is employed / not employed. (if employed please write his/her official address)

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iv. That I have already submitted a certificate to the effect that my wife / husband is not claiming medical facilities from his / her employer.

v. That my father / mother is residing with me.

vi. That my father / mother is wholly dependent upon me and that he / she has no source of income.

vii. That the doctor consulted by me for treatment is on the approved list notified by the University.

viii. That the statements given in this form are true to the best of my knowledge and belief and that the person for whom medical expenses where incurred is wholly dependent upon me.

ix. That if any excess payment is made to me towards reimbursement of my medical bills I undertake to repay them back, failing which that may be recovered from my salary.

(PRE - RECEIPTED)
Signature of the College Employee

Name .....

Dated .....

Designation .....

Checked for payment of Rs.	verified for Payment Passed for Payment
Rupees	
S.O. Accts. **A.O.**	**Bursar** **Principal**

Entry has been made in Medical Register on Page No. .....

Office Assistant

CERTIFICATE 'A'

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

Wife/Son/Daughter/Mother/Father/of Mr. .....
employed in **RAM LAL ANAND COLLEGE.**

I Dr. ..... hereby certify :

a) That I charged and received Rs. ..... for ..... consultation on (dates) ..... at my Consultation Room / at the Residence of Patient.

b) That I charged and received Rs. ..... for administering intra muscular injections or subcutaneous on (date) ..... at my Consultation Room / at the Residence of Patient.

c) The injections administered were not for immunising 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.

e) The medicines are not stocked in the ..... Hospital for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

	Name of Medicines	Price		Name of Medicines	Price
1.	.....	.....	6.	.....	.....
2.	.....	.....	7.	.....	.....
3.	.....	.....	8.	.....	.....
4.	.....	.....	9.	.....	.....
5.	.....	.....	10.	.....	.....

e) That the patients is / was suffering from .....
and is / was under my treatment from ..... to .....

f) That the patient was not given pre-netal or posts-natal treatment.

g) That X-ray, Laboratory Test, for which an expenditure of Rs. .....
was incurred were necessary and were undertaken on my advice at .....
..... .

(Name of Hospital or Laboratory)

h) That I referred the patients to Dr. ..... for Specialist Consultation and that the necessary approval of the .....
as required under the rules was obtained.
(Name of the Chief Admin. / Med. Officer of the State)

i) That the patient required / did not required hospitalisation.

Dated .....

Signature & Designation of the Medical Officer and