#### APPENDIX - II

# APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND TREATMENT OF GOVERNMENT SERVENT AND THEIR FAMILIES.

1. Name Designation and Section :

2. Office in which Employed : Telangana State Warehousing Corporation,

"Warehousing Sadan" 2<sup>nd</sup> Floor Behind Gandhi Bhavan, Nampalli,

HYDERABAD - 500 001.

3. Pay of the Government servant as defined in FRs and other Employments which should be shown separately.

4. Place of Duty

5. Full Residential Address with Door No and Name of the street

6. Name of the patient, his/her
Relationship to the Government
Servant (in case of children state
Age also).

7. Place at which the patient fell ill:

8. Nature of illness and its duration:

9. Details of amount claimed, cost of Medicines purchased from the market list of medicines, cash memos and the essentiality certificate should be attached. (each in duplicate signed by the Concerned doctors)

10. Total Amount claimed :

11. List of enclosures :

Declaration to be signed by the Government Servant

I hereby declare that the statements given in this application are true to the best of my knowledge and belief and that the person on whom medical expenses were incurred, is a member of my family, as defined under the government servant Medical Attendance rules and wholely dependant upon me.

Signature of Government Servant And Office to which attached.

### **DEPENDENT DECLARATION CERTIFICATE**

I (Full
name & Designation hereby declare that my father / Mother Sri / Smt.
has no property or income of his / her own
and that he / she is wholly dependent upon me.
Station:
Date: Signature & Designation

## NON DRAWAL CERTIFICATE

Certified that the claim of reimbursement of medical expenses incu	ileu
by Sriretired/working	as
on his treatment	for
from to	at
Hospitals amounting	g to
Rs(Rupees	
Only) was neither preferred nor continuous	ırawn
previously.	

Signature and designation

### **EMERGENCY ADMISSION CERTIFICATE**

This is to certify that Mr. / Mrs./Ms			
W/oaged	aboutadmitted in		
our hospital in	.Department under emergency on		
at am / pm.			
The provisional diagnosis is	***************************************		

Signature and designation of the attending medical authority

### **ESSENTIALITY CERTIFICATE**

I Certify that Mrs. / Mr. / Miss	S
Wife/Son/Daughter of Mr/Mrs	employed in
the	has been under my treatment for
diseases from	
at	
and that the under mentioned medicine pres	
essential for the recovery/prevention of ser	
patient . The Medicines are not stocked in	
( for supply to patients) and do not inclu-	
cheaper substance of equal therapeutic value	
are primarily foods, toilets of disinfectants.	
•	
Name of Medicines/Bill No.	Price
	The state of the s
••••••	***************************************

Signature and Designation of Authorized Medical Attendant

Signature of the Medical Officer in charge in the case of the hospital

#### CERTIFICATE - A

(To be completed in the case of patients who are not admitted to hospital for treatment for the following cases only along with ORIGINAL OUT PATIENT (OP) SLIP FROM CONCERNED DOCTOR) (Chemotherapy, Radiotherapy for cancer, Regular dialysis for Kidney, Cardinal cases like

cardiac cases, Severe neurological problems and A.I.Ds subject) 1. I Dr. ...... hereby certify a) That I charged Rs. ..... for ..... consultation on ..... at my consultation room / at the residence of the patient. b) That I charged Rs. ..... for administering intramuscular/ intravenous / subcutaneous injections on...... (Dose to be given) ay my consulting room at the residence of the patient c) That injections administrated repay in formatting or propyloction purpose. d) That the patient has been under treatment at ......hospital 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 ......hospital and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available or preparations which are primarily foods, tonics, toilets or disinfectants. Cost Name of the Medicine ............ ........... ...... ........... .......... e) That patient is / was suffering from ...... And is / was under my treatment from ..... f) That the patient was / not given prentation post treatment g) That the X ray, Laboratory tests etc, for which an expenditure of Rs. ..... was incurred was necessary and was under taken on my active at the ...... (name of the hospital or laboratory. h) That referred the patient of Dr......for specialist multilation and that the necessary approval of Director, Medical Service as required under the rules was obtained and i) That the patient did not require / required hospital etc. Signature and Designation

of the Authorized Medical Attendance

Date .....