NAGALAND UNIVERSITY

HEADQUARTERS : LUMAMI

(A Central University established by the Act of Parliament No. 35 of 1989)

Form for Reimbursement of Medical Claims

1. Full Name of the Employee/Card holder : _____
2. ID No. and Designation : _____
3. Department in which employed : _____
4. Place of Duty : _____
5. Basic Pay + Grade Pay : _____
6. Telephone/Mobile No. : (O) _____ (R) _____
7. Name of the Patient & his/her relationship with the employee: _____

   _____
8. Place at which the Patient fell sick : _____
9. Name of the Hospital & Address : _____

   _____
10. Date of Admission: _____ Date of Discharge: _____
    (in case of indoor treatment only)
11. Total Amount claimed: (a) OPD Treatment : _____

    (b) Indoor Treatment : _____
12. Details of Permission : _____
13. Details of Medical Advance obtained, if any : _____
14. List of enclosures:

    (a) _____ (b) _____
    (c) _____ (d) _____
    (e) _____ (f) _____
    (g) _____ (h) _____
    (i) _____ (j) _____
    (k) _____

DECLARATION BY THE EMPLOYEE

I hereby declare that the statements furnished in the application are true to the best of my knowledge and belief and certified that the medical expenses incurred is wholly dependent upon me/self.

Date: …….. Signature of the Employee: ……

ESSENTIALLY CERTIFICATES

Certificate 'A'

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

Certified that Mrs./Mr./Miss. …… Wife/son/daughter of Mr. …….. employed in the ……..

I, Dr. ……. hereby certify:-

a) That I charged and received Rs. …… for room/at the residence of the patient.
b) That I charged and received Rs. …… for administering …… Intravenous/intra-muscular/subcutaneous injection on …… (date to be given) at …….. my consulting room/at the residence of the patient;
c) That the injections administered were not/were from immunizing or prophylactic purposes;
d) That the patient has been under my 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 precautions for which cheaper substances of equal therapeutic value are available nor preparations which are primary foods, toilets or disinfections.

Name of Medicines/Surgical Sundries/ Laboratory Appliances/Miscellaneous	Quantity	Price
1. ……	……	……
2. ……	……	……
3. ……	……	……
4. ……	……	……
5. ……	……	……
6. ……	……	……
7. ……	……	……
8. ……	……	……
9. ……	……	……
10. ……	……	……
11. ……	……	……
12. ……	……	……
13. ……	……	……
14. ……	……	……
15. ……	……	……

(use extra sheet for continuation of answer/Sl.No. and obtained signature of the concerned Dr.)

e) That the patient is/was suffering from …… and is/was under my treatment from …… to ……;
f) That the patient is/was not given pre-natal or post-natal treatment;
g) That the 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/Laboratory);
h) That I referred the patient to Dr. …… for specialist consultation and the necessary approval of the …… (Name of the Chief Administrative Officer of the State) as required under the rules was obtained;
i) That the patient did not require/required hospitalization.

Signature of AMA/Designation of the
Medical Officer and Hospital/
Dispensary to which attached

Date: ……..

N.B.: Certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by the Medical Officer in all cases.

Certificate 'B'

(To be completed in case of patients who are admitted to hospital for treatment)

Certificate granted to Mrs./Mr./Miss. …… Wife/son/daughter of Mr. …….. employed in the ……..

PART 'A'

I, Dr. ……. hereby certify:-

a) That the patient was admitted to hospital on the advice of …… ……..(Name of the Medical Officer)/on my advice;

b) That the patient has been under treatment at ……. 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 precautions for which cheaper substances of equal therapeutic value are available nor preparations which are primary foods, toilets or disinfections.

Name of Medicines/Surgical Sundries/ Laboratory Charges/Special Devices/ Artificial Appliances/Miscellaneous	Quantity	Price
1. ……	……	……
2. ……	……	……
3. ……	……	……
4. ……	……	……
5. ……	……	……
6. ……	……	……
7. ……	……	……
8. ……	……	……
9. ……	……	……
10. ……	……	……
11. ……	……	……
12. ……	……	……
13. ……	……	……
14. ……	……	……
15. ……	……	……

(use extra sheet for continuation of answer/Sl.No. and obtained signature of the concerned Dr.)

c) That the injections administered were/were not for immunizing or prophylactic purposes;

d) That the patient is/was suffering from …… and is/was under my treatment from …… to ……;

e) That the 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/Laboratory);

f) That I called on to Dr. …… for specialist consultation and the necessary approval of the …… (Name of the Chief Administrative Officer of the State) as required under the rules was obtained;

Signature and Designation of the
Medical Officer and incharge of the
Case at the Hospital

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, or at the residence of the patient, and

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.

_____

PART 'B'

I certify that the patient has been under treatment at the _____ Hospital and that the service of the special nurses for which an expenditure of hospital and that the service of the special nurses for which an expenditure of Rs. _____ was incurred, vide bills and receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer
Incharge of the case at the Hospital

COUNTERSIGNED
Medical Superintendent
…….. Hospital

I certify that the patient has been under treatment at the _____ _____Hospital and that the facilities provided were the minimums, which were essential for patient's treatment.

Medical Superintendent
…….. Hospital

Place: ……

N.B.: Certificates not applicable should be struck off. Certificate (s) is compulsory and must be filled in by the Medical Officer in all cases.

G.A.R.23

MEDICAL CHARGES REIMBURSEMENT BILL

Bill No.: _____

Ministry/Department/ Office of _____

for the month/year _____

Head of Account:-

Sl. No.	Section of establishment and name of the incumbent	Gross claim	Recovery of advance	Net Amount payable	Remarks
1	2	3	4	5	6

Net Amount required for payment (in words) Rupees _____

Certified that I have satisfied myself that the amount included in bills drawn 1 month/2 months/3 months previous to this date, with the exception of those detailed below (of which the total has been refunded by deduction from this bill) have been disbursed to the Government servant therein named.