मौलाना आज़ाद नेशनल उर्दू यूनिवर्सिटी مولانا آزاد نیشنل اُردو یونیورسٹی

MAULANA AZAD NATIONAL URDU UNIVERSITY

(A Central University established by an Act of Parliament in 1998)

(Accredited "A" Grade by NAAC)

ADMINISTRATION & GOVERNANCE SECTION

MEDICAL REIMBURSEMENT CLAIM FOR INPATIENT TREATMENT

Temporary Advance if any availed: Rs……..

I.D.No……

SBI/IOB Bank A/c:
Cell No.

Note: Separate application form should be submitted for each patient:

1. Name & Designation of the employee (in block letters) :
2. Department / Section :
3. Pay including special pay :
4. Place of duty :
5. Actual residential address :
6. (i) Name of the patient and his/her relationship to the employees (age may please be indicated in case of children) :
   (ii) If married, whether wife/husband is employee :
7. Address/Place at which the patient fell ill :
8. Details of charges paid for Specialists service indicating:
   (i) Consultation on……amount paid ₹……..
   (ii) Injections on……..amount paid ₹……..
9. Charges for hospital treatment:

a) For accommodation whether it was : Rs.
Accordingly to the status or pay of the university employee, if higher accommodation than the entitled on is provided a certificate from the Medical Officer in charge to that effect that the accommodation to which the University employees was entitled was not available to be attached.

b) Operation theatre Charges : ₹

c) Surgical operation/Medical treatment : ₹

d) Pathological, bacteriological, radiological or other similar Lab tests including : ₹.

(i) The name of hospital or lab, at which undertaken : ₹

(ii) A certificate of the medical officer in-charge of the case of the hospital devising the tests : ₹

e) Medicines including special medicines : ₹.

f) Nursing charges duly supported by certificate of the medical officer advising such services : ₹.

Contd…2

g) Ambulance Charges receipts indicating the amount, the journey to and fro undertaken (along with essentiality certificate) : ₹

h) Any other charges eg. Electric lighting, fans, heater, air conditioning etc, indicating whether the facilities normally provided to all patients and no choice was left to patient. : ₹

10. Total amount claimed :

11. List of enclosures :
(i) Essentiality certificate 'B' dated : …….
(ii) (a) Doctor's prescription dated : …….
(b) Certificate dated : …….

(iii)	Cash memo No. & Date	Name & address of the medical Shop	Name of the medicine and quantity	Price ₹ Ps.

(iv)

(a) Receipt for room rent paid No……dated……..₹……
(b) (a) Receipt for room rent paid No……dated……..₹……
(c)
(d)
(e)

12. Declaration:

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and that the patient for whom medical expenses were incurred is wholly dependent upon me.

Station:

Date:

Signature of the University employees

FOR USE IN FINANCE & ACCOUNTS DEPARTMENT

I. Fee paid for accommodation ₹

Outside Medicines ₹

Medicines provided in Hospital ₹

Surgeon Charges ₹

Anaesthelist Charges ₹

Laboratory Test ₹

For other services ₹

II. Amount paid so far ₹.

Amount of the bill Rs.

Progressive total Rs.

(i) Passed for ₹……..(Rupees……..……Only)

(ii) For adjustment ₹……(Rupees……Only)

Dealing Assistant ***Section Officer*** ***Asst. Finance Officer***

Contd….3

Certificate granted to Mrs./Mr./Miss……wife/son/daughter

of……..employed in the……

CERTIFICATE "B"

(To be signed by the Medical Officer in-charge of the……..case of the hospital).

I, Dr…….hereby certify the following

(a) That the patient was admitted to hospital on the advance of……on my advice…… (name of medical officer).

(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 and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods toilets or disinfectants.

NAME OF MEDICINES	PRICE ₹. Ps.

(c) That the injections administered were/were not for immunising or prophylactic purposes.

(d) That the patient is/was suffering from……..and is/was under treatment……..to……..

(e) That the X-Ray, Laboratory tests etc for which an expenditure of Rs……..incurred were necessary and were undertaken on my advice at……..(name of hospital or laboratory).

(f) That I called on Dr……for specialist consultation and that the necessary approval of the ……(name of the chief Admn. Medical Officer of the State as required under the rules was obtained.

Signature and Designation of the
Medical Officer-in-charge
Of the case at the hospital

Contd…4

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 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-in-Charge
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 minimum which were essential for the patient's treatment.

Medical Superintendent

Place……

Date……..

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

**** The minimum facilities certificate may be signed either by the Medical Superintendent of the hospital concerned or another Gazetted Medical Officer who has been authorised in this behalf by the Medical Superintendent.***