


North-Eastern Hill University

NEHU Campus, Shillong - 793 022 (Meghalaya)

FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND FOR TREATMENT OF THE EMPLOYEES OF NEHU AND THEIR FAMILIES FOR TREATMENT IN A HOSPITAL.

Separate form should be used for each Patient

1. Name and Designation of the Employee (in Block Letters) :-
2. Department of the Employee :-
3. Pay of the Employee as defined in F. R. and other emoluments which should be shown separately: :-
4. Place of Duty: :-
5. Actual residential Address :-
6. (a) Name of the patient and his / her relationship to the employee (N.B. in case of children, state age). :-
- (b) Marital Status :-
- (c) Whether employed and if so, Address of the employer and monthly income :-
7. Place at which the patient fell ill :-
8. Details of the amount claimed :-
- I **Medical Attendance** :-
- (i) *Fees for consultation indicating* :-
 - (a) *The name and designation of the Medical Officer consulted and the Hospital or Dispensary to which attached.*
 - (b) *The number and dates of consultation and the fee paid for each consultation.* :-
 - (c) *Whether consultations were had at the Hospital or consulting room of the Medical Officer or at the residence of the patient* :-
- (ii) *Charges for pathological, Bactiriological, Radiological or other similar tests undertaken during diagnosis indication.* :-
 - (a) *Name of the Hospital or Laboratory where undertaken; and* :-
 - (b) *Whether the tests were undertaken on the advice of the Authorised Medical Attendant. If so, a certificate to that effect should be attached.* :-
- (iii) *Cost of medicines purchased from the market (List of Medicines, Cash Memo and essentiality certificates to be attached)* :-

II. Hospital Treatment

- Charges for hospital treatment :-
indicating separately the charges for
- (i) *Accommodation (State whether it was according to the status or pay of the employee and in the cases where the accommodation is higher than the status of the employee, a certificate should be attached to the effect that the accommodation to which he was entitled was not available).* :-
- (ii) *DIET* :-
- (iii) *Surgical operation of medical treatment* :-
- (iv) *Pathological, Bacteriological, Radiological or other similar tests, indicating :-*
- (a) *The name of the hospital or Laboratory at which undertaken; and* :-
- (b) *Whether undertaken on the advice of the medical officer in-charge of the case at the hospital. If so, a certificate to that effect should be attached.* :-
- (v) *MEDICINES* :-
- (vi) *Special medicines (List of medicines, cash memos and the essentiality certificate should be attached)* :-
- (vii) *ORDINARY NURSING* :-
- (viii) *Special nursing, i.e. nurses specially engaged for the patient state whether they were employed on the Advice of medical officer in-charge of the case at the hospital or at the request of the employee or patient* :-
- (ix) *Ambulance Charges (State the journey to and fro undertaken).* :-
- (x) *Any other charges, e.g. charges for electric light, fan, heater, air conditioning, etc, state also whether the patients and no choice was left to the patient (Hospital bills and receipts should be attached).* :-
- III. Consultation with Specialist** :-
- Fees paid to a specialist or a Medical Officer other than the Authorised medical attendant, indicating.*
- (a) *The name and designation of the specialist or the medical officer consulted and the hospital to which attached.* :-
- (b) *Number and dates of consultation and fees paid for each consultation* :-
- (c) *Whether consultation was had at the hospital. at the consulting room of the specialit or medical officer or at the residence of the patient* :-

(d) Whether the specialist or Medical Officer was consulted on the advice of the authorised medical attendant, if so, a certificate to that effect should be attached. :-

(e) Total amount claimed :-

10. List of enclosures :-

Declaration to be signed by the Government Servant :-

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

Dated: _____

Signature of the Government Servant
and Office to which attached

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

Certificate granted to Mrs / Miss / Mr. _____

Wife / Son / Daughter of Mr. / Mrs. _____ employed in
the _____

PART — 'A'

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

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 in the _____

(name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances or equal therapeutic value or available nor preparations which are primarily food, toilets or disinfectants.

Sl. No.	Name of the medicines	Price
1.		
2.		
3.		
4.		
5.		

- (c) That the injections administered were / not for immunising or prophylactic purposes.
- (d) That the patient is / was suffering from _____
 _____ and is / was under treatment from _____
 to _____.
- (e) That the X-ray, laboratory test, etc. for which an expenditure of Rs. _____
 was 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 necessary approval of the _____.

Name of the Chief Administrative Medical Officer of the State as required under the rules,
 was obtained.

**Signature and designation of the Medical
 Officer in-charge of the case of the Hospital.**

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 and designation of the Medical
 Officer in-charge of the case of the Hospital.**

Countersigned

Medical Superintendent:- 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.

Place _____ Medical Superintendent, Hospital

Note: Certificate not applicable should be struck off.

Certificate (d) is compulsory and must be filled by the Medical Officer in all cases.