APPLICATION FORMS

FOR CLAIMING REFUND OF MEDICAL EXPENSE INCURRED IN CONNECTION
ATTENDANCE AND/OR TREATMENT OF CENTRAL GOVT. SERVANT AND
THEIR FAMILIES

FORM MEDICAL[OUTDOOR PATIENT]

1. Names Designation of the Govt.
   Servant(in Block Letters)....................................................................................................................
2. Married/Unmarried.................................................................................................................................
3. Whether Wife/Husband employed...........................................................................................................
4. Office in which employed.........................................................................................................................
5. Pay of the Govt. servant as Basic Pay + Grade Pay...................................................................................
6. Place of duty ............................................................................................................................................
7. Actual residential Address.........................................................................................................................
8. Name of the Patient & his/her
   Relationship to the Govt. Servant............................................................................................................
9. Place at which the patient fell ill..............................................................................................................
10. Details of the amounts claimed............................................................................................................... 
11. Medical attendance:
    (i) (a) The Name of the hospital and Medical Officer
         Or dispensary to which attached....................................................................................................... 
         (b) The number & dates of consultations
             & Fee paid for each consultations............................................................................................... 
    (ii) Nature of illness and its duration....................................................................................................
12. (a) Name of the hospital/laboratory where
      The tests were undertaken................................................................................................................
    (b) Whether the tests were undertaken on the
        Advice of the authorized M.A. if so
        Certificate to that effect should be attached................................................................................
    (ii) Cost of medicines purchased from the market................................................................................
         (List of Medicines, Cash-memos & Essentiality Certificates should be attached)
13. Total amount Claimed – (A) Cost of Medicines....................................................................................
    (B) Consultation fee............................................................................................................................
    (C) Lab Tests........................................................................................................................................
    (D) Misc. Charges.................................................................................................................................
    Total Rs.
13. Enclosures............................................................................................................................................
DECLARATION TO BE SIGNED BY THE GOVT. SERVANT

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

Signature of the Govt. Servant
And office to which attached

Date:-

FOR OFFICE USE

Bill passed for payment of Rs.................................................... towards doctor fee....................................................
Medicines ................................Tests Charges........................................Miscellaneous Charges....................................................

(Section Officer(Admn.)) ............................................... Under Secretary(Estt.) ............................................... Director(Admn.) ........................................

FOR USE IN ACCOUNTS BRANCH

Passed for payment of Rs..............(Rupees ..........................................................)

(AFA & AO)

Received a sum of Rs..............(Rupees ..........................................................)

Signature of Claimant

Expenditure is debitable to ..........................................................
Total Budget Grant for ..........................................................
Expenditure this bill ..........................................................
Expenditure so far ..........................................................
Balance ..........................................................