स्तम्भ–2

एतद्द्वारा प्रतिस्थापित परिशिष्ट

परिशिष्ट 'ग'

(भाग–पॉच–नियम–16 तथा 18 देखे)

सेवा में,

कार्यालयाध्यक्ष का नाम,

.....

.....

विषय :–चिकित्सा उपचार पर किये गये व्यय की प्रतिपूर्ति।

महोदय,

मैं...../मेरे पारिवारिक सदस्य(नाम)..... ने .....(बीमारी का नाम) के लिए .....(दिनांक) से.....तक..... .....(चिकित्सालय का नाम) में उपचार करवाया है। मैं निम्नलिखित दस्तावेजों के साथ प्रतिपूर्ति के लिए दावा प्रस्तुत कर रहा हूॅ :–

1. उपचारी चिकित्सक/चिकित्सालय के अधीक्षक द्वारा हस्ताक्षरित/प्रतिहस्ताक्षरित अनिवार्यता प्रमाण–पत्र।
2. उपचारी चिकित्सक द्वारा विधिवत् हस्ताक्षरित एवं सत्यापित मूल नकद पर्ची(कैश मेमो), बीजक(बिल), बाउचर।
3. यह प्रमाणित किया जाता है कि ऊपर नामित पारिवारिक सदस्य मुझ पर पूर्णतया आश्रित हैं और सामान्यतया मेरे साथ निवास करता है।

मेरे उपचारार्थ,.....(कार्यालय का नाम) के पत्र संख्या.....दिनांक.....द्वारा स्वीकृत ₹ ..... के अग्रिम का सामायोजन करने के पश्चात् मेरे दावे की प्रतिपूर्ति के लिए यथा आवश्यक कार्यवाही करने की कृपा करें।

दिनांक.....

अधिकारी/कर्मचारी का नाम :–.....

पदनाम :–.....

तैनाती का स्थान :–.....

चिकित्सा प्रतिपूर्ति व्यय विवरण देय-अदेय सूची

1. रोगी का नाम .....

   पिता का नाम .....

2. किस विभाग में कार्यरत है .....

   पदनाम.....वेतनमान.....

3. रोग एवं उपचार का विवरण.....

4. पूर्ण उपचारित अवधि दिनांक ..... से..... तक

   स्थान .....

5.उपचार करने वाले डॉक्टर का नाम .....

   आउट डोर/इण्डोर उपचार सम्बन्धी विवरण .....

क्रम संख्या	बिल दिनाँक	वाउचर संख्या	औषधि/चिकित्सा प्रतिष्ठान का नाम	बिल धनराशि रु.	पै.	अदेय धनराशि	देय धनराशि

प्रार्थी

नाम .....

अधिकारी के हस्ताक्षर

पिता का नाम.....

पदनाम.....

परिशिष्ट 'क'

उत्तर प्रदेश सरकार

स्वास्थ्य-पत्रक

[भाग दो, नियम-6(क) देखें]

संख्या-.....

आवेदक के परिवार का प्रमाणित फोटो

कार्यालयाध्यक्ष की मुहर

नामः- ..... जन्म का दिनांक ..... लिंग.....

पदनाम..... विभाग का नाम .....

तैनाती का स्थान-.....

आवासीय पता-.....

मूल वेतन तथा वेतनमान/पेंशन-.....

नामिनी का नाम-.....

आश्रित पारिवारिक सदस्यों का विवरण-

क्रमांक	नाम	जन्म का दिनांक	आवेदक से सम्बन्ध
1.			
2.			
3.			
4.			
5.			
कुल संख्या			

दिनांक.....

आवेदक के हस्ताक्षर

कार्यालयाध्यक्ष के प्रतिहस्ताक्षर, मुहर सहित।

FORM OF APPLICATION FOR CLAIMING REFUND OR MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE OF TREATMENT OF CENTRAL & OTHER GOVERNMENT SERVENTS ETC AND THEIR FAMILIES

1.Name and Designation of the Govt.Servant (in block letters).....

(a) Whether married or unmarried .....

(b)Wife employed or not. .....

2.Office in which employed. .....

3.Pay of the Govt. servant defined in the Pay Rs..... p.m

fundamental Rules and any other emolument. D.A Rs..... p.m

which should ne shown separately. H.R Rs.....p.m

4.Place of duty. .....

5.Actual residential address .....

6.Name of the patient and his/her relationship

to the Govt.servant(in case of children's state age also) .....

7.Place at which the patient fell ill .....

8.Details of amount claimed .....

MEDICAL ATTENDENCE

(i) Fees for consultation of Medical

(a)The name and designation of 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)The number and dates of injection paid and the fees For each injection. .....

(d) Whether consultation and or/injection Were had at the hospital,or at the consulting Room of the Medical Officer ..... or at the residence of the patient

(ii) Cost of medicines purchased from the Market,List of medicines and the. essentiality certificates should be attached Rs. .....

9.Total amount claimed. Rs .....

10.List of enclosures. Prescription.....Cash memo/Memos .....

Declaration to be singed by the Government Servant

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

Signature of the Government Servant

Office to which attached

Certificate granted to Mrs./Mr./Miss….....
Wife/Son/Daughter of Mr.....
Employed in the…….

CERTIFICATE "A"

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

I, Dr. ……...…….…… hereby certify :-

(a) that I charged and received ₹ ……..…… for ….…….consultations on …..……. (date to be given) at my consulting room……. ……...…… at the residence of the patient.

(b) that I charged and received ₹ ……..……for administering …….……. intramuscular injections/subcutaneous on……...(date to be given) at my consulting room/at the residence of the patient.

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

(d) That the patient has been under treatment at……...…….hospital/my consulting room and that the undermentioned 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 preparations for which cheaper substances of equal therapeutic value are available for preparations, which are primarily foods, toilets or disinfection.

S.N.	Name of medicines	Prices
1.		
2.		
3.		
4.		
5.		
6.		

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

(f) That the patient is/was not given prenatal or postnatal treatment.

(g) That the X-ray laboratory test, etc. for which an expenditure of ₹ ……..…….. was incurred were necessary and were undertaken on my advice at…… (Name of hospital or laboratory)

(h) That I referred the patient to Dr. ……..…….for specialist consultation and that the necessary approval of the ……..……..……..……..(Name of the Chief Administrative Medical Officer of the State), as required under the rules was obtained.

(i) That the patient did not require/required hospitalization.

Signature & Designation of the Medical Officer
Name of the Hospital/Dispensary to which attached.
Dated ……..

N.B. :-

Certificate not applicable should be struck off. Certificate (a) is Compulsory and must be filled in by the Medical Officer in all cases.

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

Certificate granted to Mrs./Mr./Miss….....
Wife/Son/Daughter of Mr.....
Employed in the…….

CERTIFICATE "B"

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

PART -A

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

I, Dr. ……..…… hereby certify :-

(a) that the patient was admitted to hospital on my advice/the advice of…… ……...(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 hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available, for preparation which are primarily foods, toilets or disinfection.

S.N.	Name of medicines	Prices
1.		
2.		
3.		
4.		
5.		

(c) That the injections administered 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 tests, etc. for which an expenditure of ₹ ……..…….. was incurred were necessary and were undertaken on my advice at……..……. …… (Name of hospital or laboratory)

(f) That I called in Dr. ……..……..…….(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

PART -B

I certify that the patient has been under treatment at the……. ……..……..……..…….....hospital and that the services of the special nurses, for which and expenditure of ₹……...……..……. was incurred vide bills and receipts attached, were essential for the recovery/prevention of serious deter-oration 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 minimum which were essential for the patients treatment.

Medical Superintendent
……....Hospital
Place : ……
Date : …….

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

अपरिहार्य/आपात दशा प्रमाण–पत्र

प्रमाणित किया जाता है कि श्री/श्रीमती.....
पुत्र/पति/पत्नी श्री.....आयु.....
वर्ष.....
रोग से पीड़ित हैं। इनका उपचार ..... में मरीज की अपरिहार्य परिस्थिति/आकस्मिकता को देखते हुये दिनांक.....से शुरू किया गया।

चिकित्सक का नाम व मुहर