



Form-B

MATA SUNDRI COLLEGE FOR WOMEN

(UNIVERSITY OF DELHI)

MATA SUNDRI LANE, NEW DELHI-110 002

Form of application for claiming refund of medical expenses incurred in connection with medical attendant and / or treatment of University/College employees and their families.

N.B. : SEPARATE FORM SHOULD BE USED FOR EACH PATIENT

1. Name & designation of the employee: (in Block Letters).....

i) Whether married or unmarried:.....

ii) If married the place where wife/
husband of the employee is
employed, (where applicable)

2. Where employed: **MATA SUNDRI COLLEGE FOR WOMEN**

3. Pay of the college employee and any other
emoluments, which should be shown separately:

4. Place of duty: **Mata Sundri Lane, New Delhi-110 002**

5. Actual residential address:

6. Name of the patient and his/her relationship to the college employee:
(In the case of children state age also)

7. Place at which patient be fell ill:

8. Details of Amount claimed:

9. Medical Attendant:

i) Fees for consultation, including

a) the name, qualification and designation of the medical officer
consulted and the hospital or dispensary to which attached.

b) the number and dates of consultation fee paid for each consultation

c) the number and dates of injections and the fee paid for each injection

d) whether consultation and/or injections were had at the hospital or at the
consulting room of the medical officer or at the residence of the patient.

(ii) Charges for pathological, bacteriological, radiological or other
similar tests undertaken during diagnosis indicating

a) the 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.

c) Cost of the medicines, purchased from market. (list of medicines,
cash memos and the essential certificate should be attached)

2. CONSULTATION WITH SPECIALIST

Fee paid to a specialist or a medical officer other than
Rs. 50/30/- the authorised medical attendant indicating.

- a) The name and designation of the specialist or medical officer
Consulted and hospital to which attached.
- b) Number and dates of consultation and the fee charged for each consultation.
- c) Whether consultation was had at the hospital or at the consulting room
of the specialist 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 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.

9. Total amount claimed :

10. List of enclosures :

- a) Prescription :
- b) Receipt :

Declaration to be signed by the College Employee.

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

Certified that there is no branch of Super Bazar or Co-op. Drug Store within the radius of 2kms. from my residence.

Dated.....

(Pre-Receipted)
Certified that :- (Signature of the College Employee)

1. Shri.....is not a member of W.U.S. Health Scheme.
2. The Patient dependent upon the applicant.
3. The details as given in the application form have been checked and verified to be correct.
4. Entered in the Register Page No.....SI. No.....
5. During the current financial year the total amount of the bills claimed towards reimbursement of the expense
incurred for the O.P.D. treatment in the recognised hospital/treatment at the clinics of the Authorised Medical Attendant
has not exceeded Rs. 500/-
6. 5% of the bill claimed towards reimbursement of the expenses incurred for O.P.D. treatment in the recognise
hospitals, treatments in the clinics of authorised medical attendant is being verified with the empties such a wrapper,
bottles, vials etc. and such empties are being destroyed since to total amount of bills claimed towards reimbursemen
of the expenses incurred for the O.P.D. treatment and the recognised hospital/treatment at the clinics of the Authorise
Medical Attendants has exceeded Rs. 500/- during the current financial year.
7. All the empties such as wrappers, bottles, vials etc. have been verified and destroyed since the total amount of th
bills claimed towards O.P.D. treatment in recognised hospital / treatment at the clinics of the Authorised Medica
Attendants has exceeded Rs. 1000/- during the current financial year.

PRINCIPAL

CERTIFICATE - B

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

P A R T - A

I, Dr.....hereby certify :-

(a) that the patient was admitted to hospital on the advice of/on my advice
.....
[Name of the medical officer]

(b) that the patient has been under treatment at
and that the undermentioned medicine 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.....for supply to private patients and
(Name of the hospital)

do not include proprietary preparation for cheaper substance of equal therapeutic value are
available nor preparations which are primarily foods, toilets or disinfectants.

1

NAME OF MEDICINES
(IN BLOCK LETTER)

PRICE

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

(d) that the patient is/was suffering fromand is/was under my 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 the necessary approval of the.....

[Name of the Chief]

Administrative Medical Officer of the state as required under the rules obtained.

Signature & Designation of the
Medical Officer charge in 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 was incurred vide bills
and receipts attached were essential for the recovery/prevention of the serious deterioration in the
condition of the patient.

Signature of the Medical
Officer-in-charge in the case
of 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

.....Hospital

Place :

N. B. Certificate not applicable should be struck off.

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