



Form-A

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 medial 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 expenses
incurred for the O.P.D. treatment in the recognised hospital/treatment at the clinics of the Authorised Medical Attendants
has not exceeded Rs. 500/-
6. 5% of the bill claimed towards reimbursement of the expenses incurred for O.P.D. treatment in the recognised
hospitals, treatments in the clinics of authorised medical attendant is being verified with the empties such a wrappers,
bottles, vials etc. and such empties are being destroyed since to total amount of bills claimed towards reimbursement
of the expenses incurred for the O.P.D. treatment and the recognised hospital/treatment at the clinics of the Authorised
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 the
bills claimed towards O.P.D. treatment in recognised hospital / treatment at the clinics of the Authorised Medical
Attendants has exceeded Rs. 1000/- during the current financial year.

PRINCIPAL

MATA SUNDRI COLLEGE FOR WOMEN
(UNIVERSITY OF DELHI)
MATA SUNDRI LANE, NEW DELHI-110 002

CERTIFICATE - A

(To be completed in the case of patient who is not admitted to the Hospital)

Certificate granted to

Father/Mother/Husband/Wife/Daughter/Son of Shri.....

employed in the office of.....

I, Dr..... hereby certify :

- a) that I have charged and received in cash Rs.....for consultation on.....
at the residence of patient/at my consultation room.
- b) that I have charged and received in cash Rs.....for administering.....intervenous
/ intra/ muscular injection on.....at my consulting room/theresidence of the patient.
- c) that the injections administered were not for immunising or prophylactic purpose.
- d) that the patient has been under my treatment at my consulting room outside the hospital hours 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 dispensary/ Government Hospital for supply to private patient and do not include proprietary preparation for which cheaper substances of equal therepactic value are available for preparations which are primarily foods, toilets or disinfections.

Bill No. & Date	Name of Medicine	Price	Name of Medicine	Price
-----------------	------------------	-------	------------------	-------

- e) that the patient is /was suffering from.....and is/was under my treatment from.....to.....
- f) that the patient is / was not given pre-natal or post-natal treatment.
- g) that the X-Ray laboratory tests etc. for which an expenditure of Rs..... (Rupees.....) was incurred were necessary and were undertaken on my advice at Government Hospital/Private Clinic.
- h) that I referred the patient to Dr.....for special consultation.
- i) that the patient did not require hospitalisation
- j) Certified that Dr.....at.....was consulted by the patient on my advise and the consultation was essential for the speedy recovery of the patient.
- k) Certified that the disease was not one of the prolonged treatment.
- l) that the treatment in in-excess of the prescribed period of ten days was essential for the recovery of the patient.
- m) that the patient has reasonable chance of recovery if he/she is treated as an our-patient.
- n) that the mixture/power could not be dispensed in the hospital and authorised the purchased from the chemist.
- o) Certified that I am practising Medicine for more that 10 days.
- p) Certified that I am practicing Allopathic System of medicine and am permitted to do so.
- q) that the patient did not require/required leave during the period of treatment.

(Signature of the Medical Officer, with Rubber Stamp)

Registration No.

Degree:

Dated:.....