FORM-A

INDIRA GANDHI NATIONAL OPEN UNIVERSITY
MAIDAN GARHI, NEW DELHI-110 068.

Form of Application for Medical Claim
(Out-door Treatment)

1.	Name & Designation (in block letters)		
2.	a. Marital Status		Married
	b. If Married, the palce where the spouse is employed		
3.	Pay of the official		
4.	Place of Duty (Division, Room No., Block No.)		
5.	Actual residential address		_____ _ _____ _ _____ _
6.	Name of the patient and his/her relationship to the employee (in case of children specify age also)		
7.	Details of amount claimed		
	i) Fees for consultation indicating:-		

Name & Description of the Medical Officer consulted	No. of consul-tation	Date of consultation	Fee Paid

ii)

Charges for injection	Numbe r	Date	Amount Paid

iii) Charges for pathological radiological or other similar tests undertaken:

Name of the Hospital/Laboratory	Name of test	Amount Paid	Receipt No. (if any)

iv) Cost of medicines purchased from the market:

Name of the Chemist shop	Cash Memo No.	Date	Amount Paid

(Cash Memos and essentiality certificates should be attached)

8. Total Amount claimed
9. List of enclosures

Signature of Claimant

DECLARATION TO BE SIGNED BY THE EMPLOYEE

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

Signature of the employee

Date:

DELCARTION IN CASE OF RETIRED EMPLOYEES

i) I am not re-employed on regular basis.
ii) I am not entiteled for medical allowance/ medical facility from any other source.
iii) My spouse is also not getting any medical facility/ Medical allowance from any other source.

Date:

Signature of retired employee

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ESSENTIALITY CERTIFICATES
CERTIFICATE 'A'

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

Certificate granted to Mrs./Mr./Miss _____ wife/son/daughter of Mr/Mrs_____ employed in the _____ _____.

I, Dr. _____ hereby certify:

a) that I charged and received Rs._____ for _____ consulation(s) on _____(dates to be given) at my consulting room/at the residence of the patient.

b) that I charged and received Rs. _____ for administrating _____ intravenous/ intra-muscular/ subcutaneous injection on _____ (dates to be given) at _____ my consulting room/residence of the patient.

c) that the injections administered were not/were for immunizing or prophylactic purposes

d) that the patient has been under my treatment at _____ hospital/my consulting room 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 do not include proprietary preparation for which cheap substitutes of equal therapeutic value are available nor preparations which are primarily foods.

S. No.	Name of the medicines (In block letters)	Price
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
	Total	

e) that the patient is was suffering from _____ and is/was under 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. _____ was incurred was necessary and were undertaken on my advice,

h) that I referred the patient to Dr. _____ for specialist consultation.

i) that the patient did not require/required hospitalization.

Signature & Designation of the
Medical Officer & Hospital/Dispensary
to which attached

Signature of Doctor and his
Medical qualification

Registration No……..