Appendix - 2

(See Rule 7 (4)),12(3),14(2)

FORM OF APPLICATION FOR MEDICAL CLAIMS

Form of application for claiming reimbursement of medical expenses in connection with medical attendance/treatment of Sikkim Government servants and member of their families as inpatients in the Hospitals.

(N.B.: - Separate form should be used for each patient)

1. Name & Designation of Government Servant:
   (In block letters)
   (i) Whether married or unmarried:
   (ii) If married, the place where wife/husband is employed:
2. Office in which employed:
3. Pay of the Government Servant.
4. Place of duty:
5. Actual residential address:
6. Name of the patient and his/her relationship to the Government Servant. (N.B in the case of children, state age also):
7. Place in which the patient fell ill:
8. Details of amount claimed:

I. Name of Hospital treatment:
Charges for hospital treatment, indicating separately the charges for:

(i) Accommodation:

(ii) Surgical operation or medical treatment:

(iii) Pathological, bacteriological, radiological or medical treatment:

(iv) Medicines (cash memos and essentiality Certificate should be attached):

(v) Special nursing, i.e., nurses specially engaged for the patient (a certificate from the Medical Officer-in-charge of the case duly countersigned by the Medical Superintendent of the Hospital/Institute to be enclosed)

II. Consultation with specialist:

(i) the name and the designation of the specialist or Medical Officer consulted and the hospital to which attached:

(ii) number and date of consultation and fees charged for each consultation (a certificate from the concerned hospital authority who advised the consultation with the specialist should be attached).

9. Total amount claimed:
10. Less advance taken:
11. Net amount claimed:
12. List of enclosures:

DECLARATION TO BE SIGNED BY THE GOVERNMENT 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 medical expenses were incurred is wholly dependent upon.

Date.....

Signature of the Government servant
and name office to which attached.

I Dr.....hereby certify that the patient is/was suffering from.....is/was under my treatment from.....to..... and that the under mentioned and medicines prescribed by me in this connection were essential for the treatment of the patient. These medicines do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations, which are primarily foods. Toilets or disinfection. The medicines are not stocked in the..... (Name of hospitals).

	Invoice No. & Date	**Price**	**Name of Medicines**	**Price**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Date.....

Signature and Designation of
Medical Officer

CERTIFICATE OF CONTROLLING OFFICER

Certified that I have after scrutiny of the claim as required under rule 21 satisfied myself that the claim is to the best of my knowledge and belief correct.

Date……

Signature and Designation of
the Controlling Officer