केरल केंद्रीय विश्वविद्यालय
CENTRAL UNIVERSITY OF KERALA
(संसद के अधिनियम, वर्ष 2009 द्वारा स्थापित / Established under the Act of Parliament in 2009)
TEJASWINI HILLS, PERIYA P.O., KASARAGOD – 671316, KERALA

MEDICAL REIMBURSEMENT CLAIM FOR OUTPATIENT TREATMENT

1. Name & Designation of the Employee :

2. Department / Branch :

3. Pay including special pay :

4. Place of duty :

5. Actual residential address :

6. Name of the patient and his/her :

7. Relationship to the Employee :

a) Whether married :

b) Whether wife is employed :

c) If so, Where :

8. Address/Place at which the patient fell ill :

9. Details of charges paid for AMA/Special Services indicating :

i) Consultation on _____ amount paid Rs. _____/-

ii) Injections on _____ amount paid Rs._____/-

10. Cost of Medicines Rs. _____/-

11. Total amount claimed Rs. _____/-

12. List of enclosures :

i) Essential Certificate '**A**' dated :

ii) Doctors prescription dated :

Cash memo No & Date	*Name & Address of the Medical shop*	*Name of the Medicines and quantity*	*Price* (Rs.)

13. Declaration:

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

Station:
Date:__ / __ /____

Signature of the Employee

CERTIFICATE 'A'

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

Certificate granted to Mrs./Mr,/Miss./Baby _____ Wife/Son/ Daughter/Father/Mother of Mr. _____Employee in the Central University of Kerala, Periya.

I, Dr. _____ hereby certify;

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

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

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

(d) That the patient has been under treatment at _____

(e) The medicines are not stocked in the _____

(Name of Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparations which are primarily foods, toilet or disinfectants.

(f) That the patient is/was suffering from _____ and is/was under my treatment from _____ to _____

(g) That the patient is / was not given pre-natal treatment.

(h) That the X-Ray, Laboratory, Test, etc., for which an expenditure of Rs. _____ was incurred was necessary and were undertaken on my advise at _____ (Name of the Hospital or Laboratory).

(i) That I referred the patient to Dr. _____ for specializations and that the necessary. Approval of the _____ (Name of the Chief Administrative Officer of the State) as required under the rule was obtained.

(j) That the patient did not require / required Hospitalization.

Signature, :
Designation & Registration No. of the Medical Officer :
Hospital & / Dispensary :

Date : __ / __ / _____

N.B: Certificates not applicable should be struck off, Certificate(s) is compulsory and filled in by the Medical Officer in all cases.

Note: *1. The above certificate may deemed to be regular receipt for the payment received by the Medical Officer, who will be required to affix a Revenue Stamp on the Essentially Certificate itself when the payment exceeds Rs. 500/-.*

2. The cash memos for purpose of medicines must be countersigned by the doctor.