CENTRAL UNIVERSITY OF KARNATAKA
(Established by an Act of the Parliament in 2009)

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Medical Reimbursement Claim for Inpatient Treatment

Temporary if any availed : Rs……..

I.D. No……..

S.B.I./A.B. Bank A/c No.

Note: Separate application form should be submitted for each patient.

1. Name & Designation of the Employee (in block letters) :
2. Department / Branch :
3. Pay including special pay :
4. Place of Duty :
5. Actual residential address :
6. i) Name of the patient and his/her relation-ship to the employee (age may please be Indicated in case of children) :
   ii) If married, whether Wife/Husband is employed, :
7. Address/Place at which the patient fell ill :
8. Details of charges paid for Specialist services indicating :
   i) Consultation on ……amount paid Rs……
   ii) Injection on ……..amount paid Rs……..
9. Charges for hospital treatment :
   a) for accommodation whether it was according to the status or pay of the univer-sity employee, If higher accommodation than the entitled one is provided a certificate from the Medical Officer in charge to that effect that the accommodation to which the Universt-sity employee was entitled was not available to be attached, Rs.
   b) Operation theatre Charges Rs.
   c) Surgical operation/Medical treatment /confinement. Rs.
   d) Pathological, bacteriological, radiological or other similar Lab, tests indicating : Rs.
   i) The name of the hospital or lab, at which undertaken. Rs.
   ii) A certificate of the medical officer in-Charge of the case of the hospital devising the tests. Rs.
   e) Medicines including special medicines. Rs.
   f) Nursing charges-duly supported by certify-cate of the medical officer advising such services.

g) ambulance Charges-receipts indicating the amount, the journey to and for undertaken, (along with essentiality certificate) Rs.

h) any ather charges eg. Electric lighting, fans, heater, air conditioning etc., indicating whether the facilities normally provided to all patients and no choice was left to patient.

10. Total amount claimed :

11. List of enclosures :

i) Essentiality Certificates 'B' dated: ……

ii) (a) Doctor's prescription dated ……..

(b) Certificate dated……

iii)

Cash Memo No. & Date	Name & Address of the Medical Shop	Name of the medicines and quantity	Price Rs.	Ps.

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iv) (a) Receipt for room rent paid No……date……Rs……...
(b) Receipt for diet charges No……date……Rs……
(c)
(d)
(e)

12. Declaration :

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

Station :
Date :

Signature of the University Employee

FOR USE IN FINANCE & ACCOUNTS DEPARTMENT

I Fee paid for accommodation	Rs.	II. Amount paid so far	Rs.
Out side Medicines	Rs.	Amount of the bill	Rs.
Medicines provided In Hospital	Rs.	Progressive total	Rs.
Operation Theatre	Rs.		
Surgeon Charges	Rs.		
Anesthetist Charges	Rs.		
Laboratory Test	Rs.		
For other services	Rs.		

i) Passed for Rs…… …(Rs……only)

ii) For adjustment Rs……..(Rs……only)

Dealing Asst. **S.O.** **Asst. Finance Officer/D.F.O.**

Certificate granted to Mrs./Mr./Miss……..

…….wife/son/daughter of. …… ……..

…….. …….employee in the ……

……

CERTIFICATE 'B'

(To be singed by the Medical Officer In-charge of the ……..

…….case of the hospital)

I, Dr……..hereby certify

a) that the patient was admitted to hospital on the advice of /
on my advice……
(name of medical officer)

b) that the patient has been under treatment at……
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 pat lent.
The medicines are not stocked in the… ……..
(name of hospital)
Supply to private patient and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods toilets or disinfectants.

NAME OF MEDICINES	PRICE Rs.	Ps.

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

d) That the patient is / was suffering from ……
and is / was under treatment ……..to ……..

e) that the X-Ray, Laboratory tests, 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 Admn, Medical Officer of the State)
As required under the rules, was obtained.

Signature, Designation of
the Medical Officer-in-charge
of the case at the Hospital

P A R T – B

I Certify that the patient has been under treatment of the …….. Hospital and that the service of the special nurses, for which an expenditure of Rs……was Incurred vide bills and receipts attached, were essential for the recovery./prevention of serious deterioration in the condition of the patient.

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

Place:……. hospital

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

* The minimum facilities certificate may be signed either by the Medical Superintendent of the hospital concerned or another Gazzetted Medical Officer who has been authorized in this behalf by the Medical Superintendent.

(GOI., M.H.O.M.No. F.2-35/52-LSG (H.I.), dated the 19th September 19 9)