

**CENTRAL UNIVERSITY OF
KARNATAKA**

(Established by an Act of the Parliament in 2009)



CENTRAL UNIVERSITY OF KARNATAKA

Kadganchi, Aland Road

Gulbarga 585 311

Phone(08477)-226702

Tele fax : 225703

Website: www.cuk.ac.in

Email: cukgulbarga@gmail.com

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 onamount paid Rs.....
 - ii) Injection onamount paid Rs.....
9. Charges for hospital treatment :
 - a) for accommodation whether it was Rs.
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,
 - b) Operation theatre Charges Rs.
 - c) Surgical operation/Medical treatment Rs.
/confinement.
 - d) Pathological, bacteriological, radiological Rs.
or other similar Lab, tests indicating :
 - i) The name of the hospital or lab, at Rs.
which undertaken.
 - ii) A certificate of the medical officer Rs.
in-Charge of the case of the hospital
devising the tests.
 - 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 Rs.
the amount, the journey to and for undertaken,
(along with essentiality certificate)

h) any other charges eg. Electric lighting,
fans, heater, air conditioning etc., indicat-
ing 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	Name & Address of	Name of the medicines	Price
No. & Date	the Medical Shop	and quantity	Rs. Ps.

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 signed 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 patient.
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 treatmentto
 - 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 Gazetted Medical Officer who has been authorized in this behalf by the Medical
Superintendent.