

Chhattisgarh State Minor Forest Produce (T&D) Co-op. Fed. Ltd.

A-25, V.I.P. ESTATE, KHAMARDIH, SHANKER NAGAR, RAIPUR

PHONE NO. (0771) 4065100 to 4065104 FAX : (0771) 2283594

FORM OF APPLICATION FOR CLAIMS, REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND OF TREATMENT OF EMPLOYEES AND THEIR FAMILIES

N.B. : SEPERATE FORM SHOULD BE USED FOR EACH PATIENT

1. Name and designation of the Employee. : -----
(In Block letters)

(i) Whether married or unmarried. : -----

(ii) If married, the place where Wife/Husband is : -----
employed. : -----

2. Pay of employee as defined in the Fundamental : -----
Rules and any other emolument, which should be shown separately.

3. Place of duty. : -----

4. Actual residential address. : -----
: -----
: -----

5. Name of the patient and his/her relationship to the : -----
employee . (In the case of Children stage age also.)

6. Place at which the patient fell ill. : -----

7. Details of the amount Claimed

1. MEDICAL ATTENDANCE.

(A) Fees for the consultation indicating the : -----
name , qualification and designation of the : -----
Medical Officer consulted and the Hospital : -----
or Dispensary to which attached.

(B) The number and date of consultation and the : -----
fees paid for each consultation.

(C) Whether consultation were had at the Hospital : -----
at the Consulting room of the Medical Officer
or at the residence of the patient

2. Charges for the pathological bacteriological, : -----
Mediological or other similar tests undertaken during diagnosis indicating.

(a) The name of the Hospital or Laboratory : -----
Whether the tests were undertaken.

(b) Whether the tests were taken on the advice of : -----
the authorized medical attendant , if so a
certificate to that effect should be attached.

3. Cost Of Medicines purchased from market, : Rs.-----
(that of medicines, cash memo and the essentiality
certificate should be attached) .

Total Amount Claims : Rs. -----

8. List of enclosures :-

- 1. -----
- 2. -----
- 3. -----
- 4. -----
- 5. -----
- 6. -----
- 7. -----
- 8. -----
- 9. -----
- 10. -----

DECLARATION TO BE SIGNED BY THE EMPLOYEE

I hereby declare that the statements in this application are true to the best of my knowledge and belief and the person for whom Medical Expenses were incurred is wholly dependent upon me.

Date : / / 2015

Signature of the employee

CERTIFICATE 'A'

(To be completed in the case of a patient who is not admitted to Hospital for treatment)

Certificate granted to Smt/Shri/Ku Wife/ Son/
 Daughter of Shri employed in Chhattisgarh State
 Minor Forest Produce (T & D) Co-op. Fed. Ltd. Raipur (C.G.)

I, Dr. here certify,

(A) That I, Charged Rs. (Rs.
 only for consultation(s) on at my consulting room/at the
 residence of the patient.

(B) That the patient has been under treatment at Hospital/ my consulting
 room, and that the under mentioned medicines prescribed by me in this connection were
 essential for the recovery/ preventing of serious deterioration in the conditions of the patient.

MEDICAL OFFICER

S. No	Name & Quantity of Medicines (in Block letters)	Name of Medical Shop	Cash memo No. & Date	Amount (in Rs.)

MEDICAL OFFICER

- (C) That the patient is/was suffering fromand is/was under my treatment from to
- (D) That the patient was not treated for :-
 - (i) Immunising and prophylactic purposes.
 - (ii) Sterility to sterilisation.
 - (iii) Venereal diseases and deltrium treatments.
- (E) That is was not a case of :-
 - (i) Prenatal or post natal routine checkup.
 - (ii) Testing of eye sight for glasses.
- (F) That X-ray, laboratory tests etc. dated for which the expenditure of Rs. was incurred were necessary and were undertaken on my advice at

MEDICAL OFFICER

FOR OFFICE USE

Medical expenses of the employee from April upto this Bill Rs. claim of this Bill Rs

Signature of Accountant

Passed for Rs.....(Rupees.....) for payment.

Accountant

Manager (Finance/Account)

Managing Director
