

CERTIFICATE 'B'

(To be completed in the case of patients, who are admitted to hospital for treatment)

certificate granted to

Mrs./Mr./Miss.....

wife/son/daughter of Mr.....

employed in the

PART 'A'

(To be signed by the Medical Officer in charge of the case at the hospital)

I Dr..... hereby clarify

(a) That the patient was admitted to the hospital on my advice/ advice of

.....
(Name of the Medical Officer)

(b) That the patient has been under treatment at
..... and that the undermentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of patient.

The medicines are not stocked in the
for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available, nor preparations which are primarily foods, toilets.

Sl. No.	Voucher No.	Date	Institute/Chemist's Name	Amount	Payable Amount	Non Payable Amount
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2-						
3-						
4-						
5-						
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32-						
33-						
34-						
					Total	

(c) That the injections administered was/were not for immunising or prophylactic purposed.

(d) That the patient is/was suffering from.....
and is/was under my treatment from..... To.....

(e) That the X-ray, Laboratory tests etc. for which an expenditure of Rs.
was incurred were necessary and were under taken on my advice at
.....

(Name of the hospital or Laboratory)

(f) That I referred the patient to Dr.
.....for sp[ecialist consultation and that the necessary approval of the.....
.....

(Name of the Chief Administrative Medical Officer of the.....
.....) as required under the rules was obtained.

Signature and Designation of the
Medical Officer in Charge
Of the case at the hospital

Part 'B'

I certify that the patient has been under treatment at the.....
.....hospital and that the services of the special nurse
With an expenditure of Rs.was incurred vide bill, receipts
attached, were essential for the recovery/prevention of serious deterioration in the
condition of the patient.

Signature and Designation of
the Medical Officer in Charge
of the case at the hospital

COUNTERSIGNED

.....Medical superintendent
.....Hospital

I certify that patient has been under treatment at thehospital and
that the facilities provided were the minimum which were essential for the patient's
treatment.

Place :
Date :

.....Medical superintendent
.....Hospital

DETAIL OF VOUCHERS/EXAMINATION CHART

Patient's Name :
Name of the Hospital :
Period of treatment :

Sl. No.	Voucher No.	Date	Institute/Chemist's Name	Amount	Payable Amount	Non Payable Amount
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				Total		

Signature of C.M.O/ C.M.S.

Column-2
Appendix as hereby substituted
APPENDIX - "C"
(SEE PART – V, RULE 16 and 18)

Name of the Head of Office:

Subject: Reimbursement of expenditure done on medical treatment

Sir,

I /My family member
Name.....) took treatment at (hospital name)
..... (disease name) from (date).....My health card
no..... I am submitting the claim with following documents for reimbursement:

1. Essentiality Certificate duly signed/ countersigned by treating doctors/ Superintendent of the Hospital.
2. Original Cash memo. Bills, Vouchers duly signed and verified by treating doctor.
3. It is certified that the above named family member is wholly dependent on me and normally resides with me.

Kindly do the needful for reimbursement of my claim after adjusting the advance of Rs
sanctioned for my treatment vide letter no dated of

Dated:

Name of Officer/Employee:
Designation:
Place of Posting:

APPENDIX VIII

Form of Certificates A and B

Certificate granted to Mr

Son of Mr.

employed in the District Court Shravasti.

CERTIFICATE A

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

I Dr. Amit Goel hereby certify

(a) that I charged and received Rs.Nil..... for consultation on residence of patient.

(b) that I charged and received Rs.Nil..... for administering –Nil-- intra-muscular-injections on sub-cutaneous at my consulting room at the residence of the patient.

(c) that the injections administered were for immunising or prophylactic purposes. were not.

(d) that the patient has under treatment at hospital/ my consulting room and the undermentioned medicines prescribed by me in this connection condition on the patient. The medicines are not stocked in the for supply to private patient.....(name of the hospital) and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily/foods, tonics or

NAME OF MEDICINES

PRICE

Sl. No.	Voucher No.	Date	Institute/Chemist's Name	Amount	Payable Amount	Non Payable Amount
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34-						
35-						
					Total	

(e) that the patient is/was suffering fromand is/was under my treatment from

(f) that the patient is/was not given prenatal or postnatal treatment.

(g) that the X-ray, laboratory test, etc. for which on expenditure of Rs..... was incurred were necessary and were undertaken on my advice at(Name of hospital or laboratory)

(h) that I referred the patient to Dr.for specialist consultation and that the necessary approval of the (Name of the Chief) as required under the rules (Administrative Medical Officer of States.)

(i) that the patient did not required hospitalization required.

Dated.....

Signature & Designation of the
Medical Officer and hospital
dispensary to which attached.

N.B. : Certificates not applicable should be struck off.

Certificates (a) is compulsory and must be filled my by the Medical officer in all cases.

COUNTERSIGNED

Medical Superinteandent
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.

Place:
Dated:

Medical Superintendent
.....Hospital