

FORM-I

SCHEME FOR MEDICAL FACILITIES TO M.C.D. EMPLOYEES

(To be issued /by Authorized Medical Attendant)

ESSENTIALITY CERTIFICATE-A

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

Certificate granted to Mrs./Mr./Miss...wife/son/daughter of Mr., employed in the Deptt...as (designation)....

I, Dr. ... certify:

- (a) that I charged and received Rs. for consultations 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 injections 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 purposes;
- (d) 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/Prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the (name of hospital), 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 or disinfectants.

Name of medicines	Price
(1)
(2)
(3)
(4)

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

.to ..

- (f) that the patient is/was not given pre-natal or post-natal treatment ;
- (g) that the X-Ray, laboratory test etc. for which an expenditure of Rs. was incurred was necessary and were undertaken on my advice at (name of the hospital or laboratory) ;
- (h) that I referred the patient to Dr. for specialist consultation and the necessary approval of the (name of the Chief Administrative Medical Officer) as required under the rules was obtained;
- (i) that the patient did not require/required hospitalization.

Dated:.....

Signature and Designation of the
Medical Officer and Hospital/
Dispensary to which attached.

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

Note :- In cases where double the rates of consultation fees are charged by the A.M.A. for night visits (between 10-00 p.m. and 6-00 a.m.) the A.M.A. should furnish a certificate showing why the night consultation was necessary.

FORM-II

SCHEME FOR MEDICAL FACILITIES TO M.C.D. EMPLOYEES

(To be issued by Authorized Medical Attendant)

ESSENTIALITY 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 Deptt. & (designation)___

I, Dr. ___ hereby certify:-

(a) that the patient was admitted to Hospital on advice of ___(Name of medical officer/on my advice;

(b) that the patient has been under treatment at ___that the undermentioned 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), 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 or disinfectants.

Name of medicines	Price
(1)
(2)
(3)
(4)

(c) that the injections used were/were not for immunization/prophylactic purpose.

*(d) that the patient is/was suffering from_____and is/was under treatment from ___;

(e) that the X-Ray, laboratory test etc. for which an expenditure of Rs. ___was incurred were necessary and were undertaken on my advice at ___(name of the hospital or laboratory;

(f) that I called on Dr. ___for specialist consultation and that the necessary approval of the ___(name of the Chief Administrative Medical Officer of the state) as required under the rules, was obtained;

Signature and Designation of the
Medical Officer and Hospital/
Dispensary to which attached.

PART B

I certify that the patient has been under treatment at the hospital and that the service of the special nurses for which an expenditure of Rs. was incurred, vide bills 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 (e) is compulsory and must be filled in by the Medical Officer in all cases.

Note :- In cases, where double the rates of consultation fees are charged by the A.M.A. for night visits (between 10-00 p.m. and 6-00 a.m.) the A.M.A. should furnish a certificate showing why the night consultation was necessary.

FORM-III

SCHEME FOR MEDICAL FACILITIES TO M.C.D. EMPLOYEES
FORM OF APPLICATION FOR MEDICAL RE-IMBURSEMENT CLAIMS BY M.C.D.EMPLOYEES

Form of application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment of Municipal Employees and their families for-medical attendance/treatment taken both from an Authorized Medical Attendant and from a Hospital.

- 1. Name and designation of Municipal Employee ... (IN BLOCK LETTERS)
(i) Whether married or unmarried ...
(ii) If married, the place where wife/husband is employed ...
2. Office in which employed ... 3. Pay of the Municipal
Employees as defined in the Fundamental ...
Rules and any other emoluments which should be shown separately
4. Place of duty ...
5. Actual residential address ...
6. Name of the patient and his/her relationship to the Municipal employees...
N.B.: -In the case of children state age also.
7. Place at which the patient fell ill ...
8. Details of the amount claimed -----

I. Medical Attendance

- (i) Fees for consultation indicating: ----
(a) the name and designation of the medical officer consulted & the hospital or dispensary to which attached ---
(b) the number and dates of consultation and fee paid for each Consultation ...
(c) The number and dates of injection and the fee paid for each injection ---
(d) Whether consultations and/or injections were had at the hospital, at the Consulting room of the medical officer or at the residence of the patient ---
(ii) Charges for pathological, bacteriological, radiological, or other similar tests Undertaken during diagnosis in dictating: ----
(a) The name of the hospital or laboratory where undertaken, and ...
(b) Whether the tests were undertaken on the advice of the Authorized Medical Attendant.
If so, a certificate to that effect should be attached. ...
(iii) Cost of medicines purchased from the market. ...
(cash memos and the essentiality certificates should be attached)

II. Hospital Treatment

- Name of the Hospital ...
Charges for hospital treatment, indicating separately the charge for :-
(i) Accommodation (State whether it was according to the status or pay of the Municipal Employee and in cases where the accommodation is higher than the status of the Municipal Employees, a certificate should be attached to the effect that the accommodation to which he was entitled was not available) ---
(ii) Diet ...
(iii) Surgical operation or medical treatment or confinement ...

- (iv) Pathological, bacteriological, radiological or other similar tests indicating :---
 - (a) the name of the hospital or laboratory at which under taken; and ...
 - (b) whether undertaken on the advice of the medical officer in charge of the case at the hospital. If so, a certificate to that effect should be attached ...

i. Medicines

- (vi) Special medicines ...

(Cash memos and the essentiality certificates should be attached)

- (vii) Ordinary nursing -----

(viii) Special nursing, i.e., nurses, specially engaged for the patient (State whether they are employed on the advice of the medical officer in charge of the case at the hospital or at the request of the Municipal Employee or patient. In the former case a certificate from the medical Officer in charge of the case and counter signed by the Medical Superintendent of the hospital should be attached).

- (ix) Ambulance charge
(State the journey-to and fro-undertaken) -----

- (x) Any other charges, e.g., charges for electric light, fan, heater, air conditioning etc. State also whether the facilities referred to are a part of the facilities normally provided to all patients and no choice was left to the patient -----

Note 1:- If the treatment was received by the Municipal Employee at his residence under Rule 7 of the C.S. (M.A.) Rules, 1944 give particulars of such treatment and attach a certificate from the Authorized Medical Attendant as required by these rules.

Note 2:- If the treatment was received at a hospital other than a Govt. hospital, necessary details and the certificate of the Authorized Medical Attendant that the requisite treatment was not available in any nearest Govt. hospital should be furnished.

III. Consultation with Specialist

Fees paid to a Specialist or a Medical Officer other than the Authorized Medical Attendant, indicating :-

- (a) the name and designation of the Specialist or medical Officer consulted and the hospital to which attached -----
- (b) number and dates of consultations and the fees charged for each consultation -----
- (c) whether consultation was had at the hospital, at the consulting room of the Specialist or Medical Officer or at the residence of the patient; and -----
- (d) whether the Specialist or Medical Officer was consulted on the advice of the Authorized Medical Attendant and the prior approval of the Chief Administrative Medical Officer was obtained. If so, a certificate to that effect should be attached -----

- 9. Total amount claimed Rs-----
- 10. Less advance taken on Rs-----
- 11. Net amount claimed Rs-----
- 12. List of enclosures -----

DECLARATION TO BE SIGNED BY THE MUNICIPAL EMPLOYEE

I hereby declare that the statements in the 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.

Counter Signed

Signature of the Municipal Employee
and office to which attached
(With date)

.....
Drawing and Disbursing Officer/
Next Superior Officer in case of Self Drawing Officer/ Controlling Authority.