FORM-I

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

(To be issued by authorized Medical Attendant)

ESSENTIAL 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. ………………………………………. hereby certify:

(i) that I charged and received Rs. ……………… for ………………….. consultations on …………………………. (date to be given) at my consulting room/ at the residence of the patient;

(ii) that I charged and received Rs. ……………… for administering ………………………… intra-venous/intra-muscular/subcutaneous injections on ……………..…(date to be given) at ………………….. my consulting room/the residence of the patient;

(iii) that the injections administered were not/were for immunizing or prophylactic purposes;

(iv) 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 for serious deterioration in the condition of the patient. The medicines are not stocked in the ……………………………..………………………(name of the 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)____________________	__________

(v) that the patient is/was suffering from ………………………….……………….and is/was under my treatment from …………………….. to ……………………………;

(vi) that the patient is/was not given pre-natal or post-natal treatment;

(vii) 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);

(viii) that I referred the patient to Dr. ……………………………………………... for specialist consultation and that the necessary approval of the ……………………………..(name of the Chief Administrative Medical Officer) as required under the rules was obtained;

(ix) that the patient did not require/required hospitalization.

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

Dated :- ………………………

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 1:- 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 6-00a.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 Medical Institution)

ESSENTIAL 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. …………………. As (designation) ……………………

PART – A

(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 ……………………………..………………(Name of the Medical Officer)/ on my advice;

(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 for serious deterioration in the condition of the patient. The medicines are not stocked in the …………………………… …..……………………… (name of the 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 administered were not/were for immunizing or prophylactic purposes;

(d) that the patient is/was suffering from …………………………..………………and is/was under my treatment from …………………….. to ……………………………;

(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 incharge of the
case at the hospital

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
incharge 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.

Signature of the Medical Superintendent
……………………………………………..Hospital

Place :- ………………………

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.

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 Employee and their families for – medical attendance/treatment taken both from and Authorised Medical attendant and 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 Employee ....
....
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 and 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 consultation and /or injection 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 indicating:-
   (a) the name of the hospital or laboratory where undertaken; and ....
   (b) whether the tests were undertaken on the advice of the Authorised Medical Attendant. If so, a certificate 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 case 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 undertaken during diagnosis indicating:- ……………………………………………

(a) the name of the hospital or laboratory where undertaken; and ……………………………………………

(b) whether the tests were undertaken on the advice of the Authorised Medical Attendant. If so, a certificate should be attached ……………………………………………

(v) 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 countersigned 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 Employees 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 Authorised Medical attendant as required by these rules.

Note 2: - If the treatment received at a hospital other than a Govt. Hospital, Necessary details and the certificate of the Authorised 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 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 Authorised 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 take on Rs. ………………………………………
11. Net amount claimed Rs. ………………………………………
12. List of enclosures Rs. ………………………………………

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.

Signature of the Municipal Employee
And office to which attached
(with date)

Countersigned

……………………………………………………………………

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

Guideline to Complete Medical Reimbursement Claim

1. Medical Reimbursement claim Form, III all the enteries in this form should be completed. Any column not applicable to be written NA.

2. All the column of Individual's particular from 1 to 8 to be completed

3. **(I) Medical Attendance: - In case of OPD treatment –** (I) Medical attendent portion to be completed from (i) to (iii) with following enclosure.
   (A) Form –I:- Essentially Certificate 'A' – To be completed and signed by the treating Doctor, All the Column have to be completed from (a) to (c).
   In (d) Details of Medicine bill to be enclosed as per ANNUXER
   In (e) Diagnosis and period of Treatment to be mentioned.
   In (g) Bills Investigation to be entered.
   (B) Copy of OPD card of Treating Hospital/ Dispensary.
   (C) In case of MCD Paneled Pvt. Hospital, referral from MCD Dispensary/ Hospital.
   (D) Summary of the OPD expenditure as per ANX "A".
   (E) All the original bill of Medicine & Lab to be signed and stamped by the treating Doctor.
   (F) Copy of previous sanctioned in any.

4. **(II) Hospital treatment:- In case of Indoor/ Hospitalization treatment –** (II) Hospital treatment portion of the claim form III to be completed with completion of all column(i) to (x) with following enclosure.
   (A) Form II:- Essentially certificate B duly stamped in all respect by the treating doctor and countersigned by the MS of hospital with stamp of treating doctor and MS of the hospital.
   (B) In case Pvt. Hospital – Referral from MCD Dispensary/Hospital in original.
   (C) In case of emergency – Emergency certificate of Hospital stating kind of emergency.
   (D) Detailed Discharge summary of the patient from the hospital
   (E) Summary of the hospital expenditure as per ANX "B".
   (F) Hospital bill with breakup of each item.
   (G) If medicines purchased from outside original bills of medicine with prescription signed and verified by treating doctor with his stamp.
   (H) Final payment receipt of the Hospital

SUMMARY OF OPD TREATMENT

1.	OPD Consultation	Date	Amount
	1		
	2		
	3		
	4		
	5		
		Total-	

2.	Investigation				
	Bill no.	Date	Investigation	Labs	Amount
	1				
	2				
	3				
	4				
				Total-	

3.	Medicine		
	Bill No.	Date	Amount
	1		
	2		
	3		
	4		
	5		
		Total-	
		G.Total-	

SUMMARY OF INDOOR/ HOSPITALIZATION TREATMENT

1. Hospital Bills.

   From____________________ to ____________________

2.	Medicine purchased from outside		
	Bill No.	Date	Amount
	1		
	2		
	3		
	4		
	5		
		Total-	

3	Any other Item			
	Bill No.	Date	Items	Amount
	1			
	2			
	3			
	4			
	5			
			Total-	
			G.Total-	

Medical Reimbursement Claim Check List

Name ____________________________Desig_______________Class A/B/C/D

1.	Medical Reimbursement Claim Form III	Yes/No	Page No.-
2.			
3.	Essentially Certificate A (For OPD Treatment) with enclose.	Yes/No	Page No.-
	i) Copy of OPD Card of MCD/Govt. Hospital/Treating Hospital	Yes/No	Page No.-
	ii) Referral Slip in Original from MCD Disp./Hospital	Yes/No	Page No.-
	iii) Summary of OPD Treatment	Yes/No	Page No.-
	iv) Original Bills of Medicines/Lab as per Summary	Yes/No	Page No.-
	v) Copy of Previous Sanctions	Yes/No	Page No.-
3.	Essentially Certificate B (for Indoor Treatment) with enclose	Yes/No	Page No.-
	i) Referral from MCD Disp./ Hospital	Yes/No	Page No.-
	ii) Emergency Certificate	Yes/No	Page No.-
	iii) Detailed Discharge Summary	Yes/No	Page No.-
	iv) Summary of Indoor Treatment	Yes/No	Page No.-
	v) Hospital Bills with Breakup	Yes/No	Page No.-
	vi) Medicine Bills	Yes/No	Page No.-
	vii) Investigation / Bills of Report	Yes/No	Page No.-

Signature of Individual