Appendix -2

(See Rule 7 (4),12(3),14(2))

FORM OF APPLICATION FOR MEDICAL CLAIMS

Form of application for claiming reimbursement of medical expenses incurred in connection with medical/attendance/treatment of Sikkim Government servants and member of their families for treatment in a Government Hospital/institution as inpatients.

(*N.B.:-Separate form should be used for each patients*)

1. Name & Designation of the Government Servant.
   (In block letters)

   i. Whether married or un-married.
   ii. If married, the place where wife/husband is employed.
2. Office which employed.
3. Pay of the Government Servant.
4. Place of duty:
5. Actual Residential Address.
6. Name of the patient and his/her relationship to the Government Servant. (N.B in the case of children state age also).
7. Place in which the patient fell ill.
8. Details of the amount claimed:
   - I Hospital treatment
     Name of Hospital
     Charge for hospital treatment, indicating separately the charges for –
   - i Accommodation-
   - ii Surgical operation or medical treatment:
   - iii Pathological, bacteriological, radiological, or other treats:
   - iv Medicine-
     (Cash memo and essentiality certificate should be attached)
   - v. Special nursing, Le.nurse specially engaged for the patient (a certificate from the medical officer in-charge of the case duly countersigned by the Medical Superintendent of the hospital should be attached.
   - II Consultation with specialist-

a) Fees Paid to a Specialist or a Medical Officer other than the authorized medical hospital to which attached-

b) the name and designation of the Specialist or Medical Officer consulted and the hospital to which attached-

c) number and dates of consultant and fees charged for each consultation (a certificate from the concerned hospital authority who advised the consultation with the Specialist 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 GOVERNMENT SERVANT

I hereby declare that the statements in this application are true to the best of my knowledge and belief and he/she person for whom medical expenses were incurred is wholly dependant upon me.

Date.....

Signature of the Government servant to name office to which attached.

ESSENTIALITY CERTIFICATE

I, Dr.....hereby certify that the patient is/was suffering from.....and is/was under my treatment from.....to..... and that the under mentioned and medicines prescribed by me in this connection were essential for the treatment of the patient. These medicines do not include proprietary preparations for which cheaper substances of equal therapeutic value are available, nor preparations, which are primary(name of hospital/institution). The medicines are not stocked in the .....name of hospitals

I also certify that the tests and examinations for which claim have been Preferred vide item 8(iii) were necessary for the purpose of diagnosis of the disease.

Name of Medicines	**Price**	**Name of Medicines**	**Price**

Signature and Designation of the Medical Officer and name of the hospital/Institution/Concerned Specialist.

CERTIFICATE OF CONTROLLING OFFICER

Certified that I have after scrutiny of the claim as required under rule 21 satisfied myself that the claim is to the best of my knowledge and belief correct.