AC/17

E.ID.No._____

NATIONAL INSTITUTE OF TECHNICAL TEACHERS' TRAINING & RESEARCH
SHANTIMARG, SHAMLA HILLS
BHOPAL-462002

FORM FOR TREATMENT AT HOSPITAL
(To be completed in the case of patients who are admitted to a hospital for treatment)

Essentiality Certificate (B)

Certificate granted to Mrs./Mr./Miss _____
Father/mother/wife/son/daughter of Mr. _____
Employed in the NATIONAL INSTITUTE OF TECHNICAL TECHERS' TRAINING AND RESEARCH, Bhopal.

PART 'A'

1. I, Dr. _____here_by 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 and also in the ANNEXURE-I 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 _____
(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 disinfeactants:

Name of medicines Price

1. _____
2. _____
3. _____
4. _____
5. _____
6. CONTINUED IN ANNEXURE-1

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

(d) that the patient is/was suffering from _____ and is/was under 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
–in-charge of the case at the hospital.

Note:- If the space for medicines to be mentioned in para -2 of 1(b) above are less, the same may be attached with certificate as Annexure-1.

PART 'B'

I certify that the patient has been under treatment at the _____ hospital and that the special nurses for which an expenditure of Rs. _____ was incurred, vide bills and 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 at the _____ hospital and that the facilities provided were the minimum which were essential for the patient's treatment.

Medical Superintendent

Place _____ _____ Hospital

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

The 'minimum facilities certificate ' may be signed either . The ' minimum facilities certificate' may be signed either by the Medical 'Superintendent of the Hospital concerned or another Gazetted Medical Officer who has been authorised in this behalf by the Medical Superintendent.

ANNEXURE TO ESSENTIALITY CERTIFICATE (B)

1(b)

SL.NO.	NAME OF MEDICINES (IN CAPITAL LETTERS)	RS. Ps.	Sl. NO.	NAME OF MEDICINES (INCAPITAL LETTERS)	Rs. Ps.
1.				B.F.----------	
2.			31		
3.			32		
4.			33		
5.			34		
6.			35		
7.			36		
8.			37		
9.			38		
10.			39		
11.			40		
12.			41		
13.			42		
14.			43		
15.			44		
16.			45		
17.			46		
18.			47		
19.			48		
20.			49		
21.			50		
22.			51		
23.			52		
24.			53		
25.			54		
26.			55		
27.			56		
28.			57		
29.			58		
30.			59		
	TOTAL				

Verified for Rupees_____

_____Only)

Signature of Doctor

APPENDIX- D

Medical Claim Form II

Application for Claiming refund of Medical ecpenses incurred in connection with Medical attendence and /or Treatment of Members of the NITTTR,Bhopal and their families.

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

1. Name and designation of claimant(in block letters):

2. office in Which employed : NITTTTR , Bhopal.

3.Pay as defined in rules ,and any other emoluments which should beshown separately. Rs._____pm.

4.Place of duty :

5.Actual residential address :

6.Name of the patient and hisher relationship to the member of the staff. N.Bin case of Children state age also :

7.Place at Which the Patient fell ill :

8. Nature of illness and its duration :

DETAILS OF THE AMOUNT CLAIMED

– Hospital TreatmentChargesfor Hospital treatment,Indicating separately the charges for:

(a) Accomodation (ward charges only) (state whether It was according to the status or pay of the member Of the staff and incases Where the accommodation is higher than the status of the member of the staff ,a certificate should be attached to the effect that the accommodation to which he was entitled was not available). :

(b) Diet :

(c) Surgical operation or medical treatment/or Confinement:

(d) Pathological ,bacteriological ,radiological or other Similar tests Indicating :

(i)The name of the hospital or Laboratory at which undertaken:

(II)Whether undertaken on the advice of the Medical officer In-Charge of the case at the hospital ,IF so,a certicate to the effect should be attached .

(e) Medicines:

(f) Special medicines:(List of medicines ,cash memos and the essentiality certicate should be attached) :

(g) Ordinary Nursing

(h) Special Nursing i.e.nurses specially engaged for the patient : state whether they were employed on the advice of the medical officer –In-charge of the case at the hospital or at the request of the member of the staff or patient.In the former cases a certicate from the Medical officer-In-Charge of the case and counter –signed by the medical Superintendent of the hospital should be attached.

(I) Ambulance Charges (state the Journey –to and fro undertaken):

(J) Any other charges,e.g.charges for electric light,fan,heater,: air conditioniong,etc.(state alsowhether 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 a member of the staff at his resident under rule 7 of the CS (MA) Rules 1944,give particulars of such treatment and attach certificate from the authorized medical attendant as required bu rules.

NOTE 2_ if treatment was recived at a hospital other than a Government hospital, necessary details and the certificate of the authorized medical attendant that the requisite medical treatment was not available in any nearest Government hospital should be furnished.

APPENDIX-E
Medical Claim Form III

Application for claiming refund of medical expenses in connection with medical attendance and/or Treatment of members of the NITTTR, Bhopal and their families.

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 feecharged for each consultation;

(c) Whether consultation was had at the hospital , at the room of the specialist or Medical Officer or at the residence of the patient;

(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 of the astate was obtained,if so,a certificate to that effect should be attached:

2. Total amount claimed

3. Less advance taken on

4. Net amount Claimed

5. List of enclosures

DECLARATION TO BE SIGNED BY THE MEMBER OF THE STAFF

I hereby declare that the statements in this application are true to the best of my knowledge and belief/and that the person for whom medical expenses were incurred is wholly dependent upon me and is not an earning member of the family.

Dated:

Signature of the member of the Staff, NITTTR,Bhopal

FOR OFFICE USE ONLY

Counter signed and certified that the claim:

(1) Is genuine
(2) Covered by the rules and orders on the subject:
(3) Is supported by bills,receipts and other certificates.etc.,
(4) Was not drawn before,and
(5) has been sanctioned by me

TOTAL CLAIM **Rs. _____**

DEDUCTIONS

1. In admissible medicines Rs._____
2. Doctor's fee Rs._____
3. _____ Rs._____
4. _____ Rs._____
5. _____ Rs._____

Total deduction Rs._____ _____

Net payable Rs._____

PassedforpaymentRs._____Rupees_____
_____only

Dealing Clerk Superintendent Accounts Officer