Appendix II

THE KERALA GOVERNMENT SERVANTS MEDICAL ATTENDANCE RULES, 1960.

(Proforma to be filled up by the Authorised Medical Attendant when a patient is referred to other Hospitals within/outside State).

1. Name and address of Patient. :

2. Whether employed, if so details such as
   (a) Pay & Scale of Pay. :
   (b) Office in which employed. :
3. Residential address of the patient. :

4. Place at which the patient fell ill. :
5. Whether hospitalised or not. :
6. If hospitalised whether in Government Hospital/ Private Hospital with name of Hospital. :
7. If advised hospitalisation outside the State the hospital where the patient is admitted first. State the reason for outside hospitalisation. :
8. Details of permission granted for outside treatment. :

Signature of Authorised Medical Attendant

9. (i) Remarks of Unit Chief / Head of Department.
   (ii) Remarks of Superintendent of Hospital.

Counter Signature of DME./DHS.

FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES OF GOVERNMENT SERVANTS AND THEIR FAMILIES

[Separate form should be used for each patient]

[Two copies of the application should be presented (Rule 9(6)]

1. Name and designation of Govt. Servant (Block Letters) :

2. Pay and scale of pay :

3. Office in which employed :

4. Place of duty :

5. Residential address :

6. (i) Name of patient and relationship of the Govt. Servant to the patient :

   (ii) If the patient is spouse of the employee, state whether he / she is employed, with details :

   (iii) If employed, whether the declaration of non receipt of the claim in any form is attached:

7. Place at which the patient fell ill :

HOSPITAL TREATMENT

8. Whether hospitalised or not :

9. If hospitalised whether in Govt. Hospital or Private (notified) Hospital and the name of hospital :

10. If hospitalised outside the state :

    (i) Whether the patient was on duty :

    (ii) Name of Institution :

11. If on special treatment outside the state :

    (i) Name of institution :

    (ii) Whether certificate of director of Health Service as contemplated in Rule 7(a) is attached :

    (iii) Whether prior sanction of Director of Health Services has been obtained :

12. Last date of treatment :

SUKUMAR

P.T.O.

CHARGES

13. Details of amount claimed (List of Medicines, Cash memo and Essentiality certificate should be attached) :

    (i) Treatment in Govt. Hospital, Medicines :

    (ii) Treatment in Private Institutions (bills to be certified indicating emergency of the case) :

    1. Charges for medicines :
    2. Charges for treatment :
    3. Charges of accommodation :
    4. Charges for laboratory services etc. :
    5. Charges for diet :

14. Total amount claimed (in figures and words) :

15. List of enclosures:-

    1. Essentiality Certificate :
    2. List of Cash bill :
    3. Certificate of Medical Officers :
    4. Certificate and Declaration :

DECLARATION

[To be signed by the Government Servant]

I hereby declare that the statements given above are true to the best of my knowledge and belief and that the person for whom medical expenditure has been incurred is wholly dependent on me.

Place:

Date:

Signature of Government Servant

DECLARATION

I.....employed in the.....Department as;.....hereby declare that I.....(relationship).....of me / have / has been under treatment at the ..... Hospital / Dispensary. My / his / residence and during continuing and not taken advantage of more than one system simultaneously.

Place.....

Date..... Name and Designation

CERTIFICATE

Certified that Shri / Smt.....
solely dependent on me.

Place.....

Date..... Name and Designation

DECLARATION

I, do hereby declare that excess Medical Reimbursement if any drawn or irregular payment of Medical Reimbursement if any made shall be refunded on further verification.

Name and Designation

DECLARATION

I certified no other reimbursement claim pertaining to the some period has been preferred by way of spilliting the claim by him or by some other dependents.

Name and Designation

OP / IP NO. :

FORM OF ESSENTIALITY CERTIFICATE

I certify that Shri / Smt .....

employed in the .....

Department has been under treatment at this Hospital / Dispensary or at his / her residence for the period from ..... to ..... and 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. They do not include proprietory preparations for which cheaper substance of equal therapeutic value are available, not preparations which are primary foods, tonics, toilet preparations or disinfectants.

It is certified that the case did not require hospitalisation but is one of prolonged nature requiring medical attendance at the out patient department spreading over a period of more than 10 days.

The patient was / has been suffering from .....

.....

..... (Name of disease)

Trade / Brand Name of Medicines	Chemical / Pharmacological Name of Medicine	Description	Price Rs.	Price Ps.

(Office Seal)

Signature, Name and Designation of the Authorised Medical Attendant

Date .....

..... Name of Institution

SUKUMAR