उत्तर प्रदेश आयुर्विज्ञान विश्वविद्यालय

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पत्र संख्याः /U.P.U.M.S./MRC/2025-26 दिनांकः

चिकित्सा प्रतिपूर्ति समिति द्वारा परीक्षण का प्रारुप

1.कर्मचारी का नाम .....

2.मोबाइल नंबर .....

3.अकाउंट नंबर .....

4.वेतन मान .....

5.रोगी का नाम .....

6.कर्मचारी/अधिकारी से रोगी का सम्बन्ध .....

7.रोग .....

8.आश्रित होने का प्रमाण –पत्र(हैल्थ कार्ड क स्वप्रमाणित प्रति संलग्न करे) .....

9.चिकित्सा अवधि .....

10.चिकित्सक का नाम व पदनाम .....

11.प्रतिपूर्ति हेतु दावे की धनराशि .....

12.समिति द्वारा प्रतिपूर्ति हेतु संस्तुति अर्ह धनराशि .....

13.अनर्ह पायी गयी धनराशि .....

14.अनर्हता का कारण .....

मेडिकल बोर्ड के संस्तुतिकर्ता प्राधिकारी

हस्ताक्षर **हस्ताक्षर** **हस्ताक्षर** **हस्ताक्षर** **हस्ताक्षर**

बिन्दु 1 से 11 तक के कॉलम का आवेदक द्वारा स्वयं भरा जाना है।

उत्तर प्रदेश आयुर्विज्ञान विश्वविद्यालयसैफई, इटावा (उ0प्र0)
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APPLICATION FOR MEDICAL REIMBURSEMENT

Name of Employee ..... Designation .....

Deptt..... .....S B A/c No ..... Basic Pay of the employee .....

Status of Employment (Substantive / Probation / Contractual) ....Mob. No .....

Name of Patient..... Age ....Yrs, Relation with the Employee .....

I hereby declare that myself / aforesaid member of my family, who is dependent on me is suffering from (disease) ..... and was / is under the treatment of Dr .....Designation ..... Working with (Name of Hospital) ..... from (date) ..... to (date) .....

Details of expenditure on treatment is as under: -

S. No.	Head	Dates	Amount	Total Amount (Rs)	Supporting Receipt No. & Date
1	Consultation Charges				
2	Injection Charges				
3	Laboratory tests & investigation charges				
4	Operation / Procedure charges				
5	Bed / Diet Charges				
6	Medicines				
7	Other Charges viz		TOTAL AMOUNT		

Note: Please attach prescription and original cash memos after duly verifying and marking endorsement (Paid by me)

If the treatment has been obtained outside UPUMS Hospital, please mention reason therefore:-

.....

No. of Enclosures:

Signature of Employee

Verification

Certified that details mentioned above are correct to the best of my knowledge and cash memo etc. pertaining to treatment are according to prescription and the case is suitable for medical reimbursement.

Signature of Stamp of Treating Consultant

H.O.D. Singnature & Stamp

APPENDIX –XIV

ESSENTIALITY CARTIFICATES

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.....

I. Dr. ..... hereby 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 injection 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 andthat 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 the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants

Name of medicines	Price
1	.....
2	.....
3	.....
4.....	.....

That the patient is /was suffering form ..... and is/ was under my treatment from ..... to .....;

(e) That the patient is /was not given pre-natal or post-natal treatment.

(f) 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 of laboratory).

(g) That I referred the patient to Dr ..... for Specialist consultation and that the necessary Approvalof the ..... (Name of the Chief Administrative Officer of the State)as required Under the rules was obtained.

(h) That the patient did not require /required hospitalization

Dated.....*Signature of AMA/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

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_____

PART - A

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 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 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/were not for immunizing or prophylactic purposes;

(d). that the patient is / was suffering from _____and is / was under treatment form_____ _to_____

(e). that the X-ray, laboratory tests, etc., for which an expenditure of Rs._____Was incurredwas necessary and were undertaken on my advice at_____ ____ (Name of 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

PART-B

I certify that the patient has been under treatment at the_____hospital and the service of the special nurses for which an expenditure for 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 treatment at the _____ hospital and that the facilities provided were the minimum which were essential for the patient's treatment.

Place_____
Date_____

Medical Superintendent
_____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.