



# DR. BHIM RAO AMBEDKAR COLLEGE

(University of Delhi)

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From of the application for claiming refund of medical expenses incurred in contact with medical attendance and / or treatment of University College employees and their families.

**N.B. Separate form should be used each patient.**

|  |  |
|--|--|
| 1. Name and designation of the employees:<br>(in Block Letters)<br>(i) Whether married or Unmarried.<br>(ii) If married the place where wife/husband of the employee is employed (where applicable)<br>In case employed, a joint declaration duly countersigned by the wife employer/husband of the child may be furnished at the time of first bill in each financial year.   |  |
| 2. Pay of the University/College employees, and any other emoluments, which should be shown separately:  |  |
| 3. Actual residential address:   |  |
| 4. Name of the patient and his/her relationship to the University/College employee.<br>Note : In the case of children state age also.  |  |
| Please at which the patient fell ill.  |  |
| Whether member of W.U.S Health Centre or not.  |  |
| In the any Med. Store run by the Coop. Society or Govt. within 2 kms. Form the residence of Claimant?  |  |
| Details of the amount claimed.<br><b>MEDICAL ATTENDANCE</b><br>Fees of consultation, including:<br>(a) The name qualification and designation of the medical officer consulted and the hospital or dispensary to which attached.<br>(b) The number and dates of injection and the paid for each injection.<br>(c) Whether consultation and/or injections were had at the hospital/at the consulting room of the medical officer or at the residence or the patient.<br>Cost of medicines, purchased from the market (list of medicines, case memos and the essential certificate should attached). |  |
| Total Amount Claimed   |  |
| List of enclosures :   |  |

**DECLARATION TO SIGNED BY THE UNIVERSITY / COLLEGE EMPLOYEES**

I hereby declare that statements in this application are true to the best of my knowledge and belief and the patient whom medical expenses were incurred is wholly dependent upon me.

(Pre-Recipient)

Date.....

Signature of the government servant and office to which attached.

Signature of the controlling authority with Office Seal.

**CERTIFICATE "A"**

Certificate granted to Mr./Mrs./Miss..... wife/son/Daughter of Mr..... employed in **BHIM RAO AMBEDKAR COLLEGE**, Wazirabad Road, Yamuna Vihar, Delhi-94.

(To be completed in the case of patients who are not admitted to the hospital for treatment).

I Dr..... hereby certify

- (a) That I charged and received Rs..... for .....consultation/on .....(date to be given) at my consulting from/at the residence of the patient.
- (b) That I charged and received Rs..... for administering/subcutaneous ..... intra muscular injections or subcutaneous ..... on .....at the .....my consulting room/residence of patient. (date to be given)

(c) That injections administered were/were not for immunizing or prophylactic purposes.

(d) that the patient has been under treatment at .....hospital/my consulting room.

and that the under mentioned medicines prescribed me in this connection were essential for the recovery/prevention of The serious deteriation of the patient.

The medicines are not stocked in 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 of disinfectants.

| Name of the Medicines<br>(In Block Letters) | Price |
|---|-------|
| 1   |       |
| 2   |       |
| 3   |       |
| 4   |       |
| 5   |       |
| 6   |       |

(e) That the patient is/ was suffering from .....and is / was under my treatment from .....to.....

(f) That the X-Ray, laboratory test etc. for which an expenditure of Rs.....was incurred were necessary & were taken on my advice at .....(Name of Lab)

(g) That I referred the patient to Dr.....for specialist consultation and that the necessary approval of the .....as required under the rules was obtained.

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

Dated.....

Signature Designation  
and Hospital to which attached.