[illegible]ANAGAR TELEPHONE NIGAM LIMITED

NEW DELHI

ANNEXURE - 1

MEDICAL REMBURSEMENT CLAIN FORM

[illegible]

A. [illegible] undergone treatment under Dr ______________________________
[illegible] clinic/at my residence ______________________________
[illegible] dependent wife/son/daughter/father/mother name ______________________________
as already declared by me has undergone tratment under Dr. ______________________________
at his clinic/at my residence ______________________________

3. The patient is/was suffering from ______________ and is/was under Treatment from ______________ to ______________.

B. I submit the following :-

1. Doctober prescription.
2. Cash Memo (S) No. (S) ______________ amount Rs. ______________
3. Doctors bill for supply of Medicines/injection and injection charges.
4. Receipt for Doctors consulation.
5. Receipt for tests carried out.
6. Receipt for specialist charges.
7. Any Other claim

My claim is for a total sum of

Consultation	:	Rs. ______________
Cash Memo	:	Rs. ______________
Tests	:	Rs. ______________
Total	:	Rs. ______________

C. I certify that the claim is true and correct

My basic pay is Rs. ______________ (as on 31.3.2005

Name ______________

Designation & Staff No. ______________

Employment particulars of the spouse, if any ______________

Residential address ______________

Office address ______________

Telephone No. ______________

Certified that I am not holding any CGHS card.

[illegible]

Signature of Govt. Servant
And Office to which attached.

After disallowing, in a dmissible items, it has been admitted, please pay Rs. ______________
[illegible] ______________ only) to
[illegible]/Kumari ______________

[illegible] Total Rs. ______________
[illegible] Account ______________
[illegible] ______________

Controlling Authority
Recived Payment

Signature

[illegible] should be deleted.
[illegible] should be made for self and family.
[illegible] on quartely basis, i.e. 30 June, 31st Sept., 31st Dec. & 31st March.
[illegible])

MAHANAGAR TELEPHONE NIGAM LIMITED

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

(To be signed by the medical officer In-charge of the _____ case of the hospital).

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 ;

S. No.	*Name of Medicines*	*Prices*
1.		
2.		
3.		
4.		
5.		

(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 tests, etc., for which and expenditure of Rs. _____ was incurred were necessary and were undertaken on my advice at _____ (Name of hospital or laboratory);

(f) that I called on Dr. _____ for specialist consultant 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 II

I certify that the patient has been under treatment at the _____ hospital and that the service of the special nurses for which 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

COUNTERISNED
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 toh patient's teratment.

Medical Superintendent
_____ Hospital

Place _____

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