FOR RETIRED WORKERS ONLY

INDIAN STATISTICAL INSTITUTE

Medical Assistance Scheme

Claim Bill for treatment in Hospital
(A separate form should be used for each patient)

1. Name of the Retired worker (IN BLOCK LETTERS)(with Roll No) :

2. Office to which last attached :

3. Basic Pay last drawn at the time of retirement :

4. Name of the patient and his/her relationship to the retired worker :

5. Residential Address :

6. Place at which patient fell ill :

7. PPO No./Medical Card No. :

8. Details of the amount claimed for Hospital treatment

   i) Accommodation :

   ii) Diet :

   iii) Pathological/Bacteriological Radiological or other Similar tests :

   iv) Cost of Drugs

      a) Supplied by Hospital :

      b) Purchased from outside (Cash Memos etc. to be enclosed) :

   v) Special/Ordinary Nursing, Ayah charges(Part-B in Essentiality Form should be enclosed) :

   vi) Cost of Blood, Sera, Special appliances etc. (Cash Memos, receipted bills etc. are to be attached) :

9. Consultation with Specialist : (Designations, dates of consultation and the hospital to which attached, fees charged for each consultation should be mentioned)

10. Total amount claimed Rs.....Rupees(in words).....

.....

11. List of enclosures : i) Essentiality Certificate, ii) .....

Prescriptions, iii) ..... Cash Memos, iv) .....Money

receipts.

DECLARATION

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.

Dated :

Signature of the claimant
(Retired worker/spouse)

Med. Card No./PPO No.....

Office to which attached.....

INDIAN STATISTICAL INSTITUTE

Medical Assistance Scheme

Essentiality form for Treatment in Hospital

Certificate granted to Shri/Shrimati.....

r :/husband/s wife of Shri/Shrimati.....

employed in the Indian Statistical Institute, Centre.....

CERTIFICATE B

(To be completed in the case of patients who are admitted to hospital for treatment)

Part A

(To be signed by the Medical Officer-in-Charge of the case at the hospital)

I, Dr.....heareby certify :—

(a) that the pastient was admitted to hospital on my advice/thc advice of..... (name of medical officer).

(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 hospital) for supply to private patients and do not include proprietory preparations for which cheaper substances of equal therapeutic value are available, nor preparations which are primarily foods or disinfectants.

Serial No.	*Name of Medicines* (IN BLOCK LETTERS)	*Prices* Quantity	Rs.	P.
1.	.....	.....	.....	.....
2.	.....	.....	.....	.....
3.	.....	.....	.....	.....
4.	.....	.....	.....	.....
5.	.....	.....	.....	.....
6.	.....	.....	.....	.....
		Total	.....	

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

(d) that the patient is/was sufferimg from.....and is/was under my treatment from.....to.....

(e) that the X-ray, laboratory tests, for which an expenditure of Rs.....was incurred were necessary and were undertaken on my advice at.....(name of hospital or laboratory).

(f) that I called in Dr.....for specialist consultation.

(g) that Blood, Sera, Special appliances, were recommended as unavoidably necessary and purchases thereof were made on my authority at a total cost of Rs..... Rs. in words).....from.....

.....

Signature and Designation of 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 that the services of the special nurses, for which an expenditure of Rs.....(words) 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.

Medical Superintendent

Place.....

Date.....

.....*Hospital*

N.B.—*Certificates not applicable should be struck off. Certificate(d) is compulsory and must be filled in by the Medical Officer in all cases.*

P. & P. Unit—