APPLICATION FORM FOR REIMBURSEMENT OF MEDICAL CHARGES IN RESPECT OF SERVING/RETIRED GOVERNMENT SERVANT AND HIS/HER DEPENDENTS

## PART-A

1. Name, designation, BPS, of the serving/retired Federal Government servant, (Alive/Deceased) _____
   _____
2. Name of the patient and relationship with the claimant as dependent, as specified in rule 2(d) of the Federal Services Medical Attendance Rules, 1990_____
   _____
3. Diagnosis of the patient _____
4. Ministry/Division/Department/Office of the serving/retired Government servant at Sr. No. 1 _____
   _____
5. Vendor No. and PPO No. for retired _____
6. List of medicines with quantity/hospital bill/laboratory and other diagnostic charges etc for which reimbursement is claimed through this bill (format attached).

## PART-B

Certificates by Government servant (or member of his family in case of deceased Government servant)
Certified that:

i) The member(s) of my family for whose treatment reimbursement has been claimed is wholly dependent upon me.
ii) The claim was not drawn before.
iii) I shall have no objection to the recovery of my amount overpaid, if any, from my pay/pension or otherwise.

Signature: _____
FULL NAME OF THE GOVERNMENT SERVANT
or (claimant family member in case of deceased)

_____
(IN BLOCK LETTERS)

Date: _____

## CERTIFICATES BY THE AUTHORIZED MEDICAL ATTENDANT

Certified that the medicines/drugs/hospitalization/clinical tests / examinations listed below were essential for the recovery and restoration of the patient, Mr. /Mrs. /Miss. _____

2. It is further certified that neither the medicines/drugs etc. nor their effective substitutes could be supplied from the hospital/dispensary.

Signature_____
Designation _____
Official Stamp _____

Dated: _____

## COUNTERSIGNATURES

**Departmental Controlling Authority**

Signature _____
Designation _____
Official Stamp _____

**Hospital Authority**

Signature _____
Designation _____
Official Stamp _____

(Revised application form March, 2006)

| S.# | No. & Date of Bill/Cash Memo | Name of the Chemist Shop/Hospital/Clinic/Dispensary | Name of Drugs/Medicines with Quantity/Details of Tests etc | Amount Rs. |
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Signature: _____

_____
Full Name of the Government Servant

(Revised application form March, 2006)