Date:

Place:

To

The, HM/ MEO

Mandal,
District.

Sir,

**Sub:** Request to sanction the Medical Reimbursement in repect of SRI._____,SGT/SA ( ),_____,_____ Mandal, _____District - Proposals submitted - Reg.

**Ref:** 1. G.O. Ms.No. 74, M&H Dept., dated: 15-03-2005.
2. G.O. Ms.No. 105, M&H Dept., dated: 09-04-2007.
3. Medical Bills issued by the Doctor concerned.

**-o0o-**

With reference to the subject cited, I submit here with the Medical Bills with all the enclosures for Medical Reimbursement for an amount of Rs._____=00 (Rupees (Rupees_____ only), as I have undergone Treatment for the disease _____ in the Recognised Hospital by the Andhra Pradesh State Government i.e., at _____ during the period from_____ to _____ and onward transmit to the higher authorities for further necessary action in the matter at an early date.

Thanking you sir,

Yours Faithfully

Signature of the employee

**Encl:-**
Essentiality Certificate
Emergency Certificate
Discharge summary
I.P Finalbill
Medical Bills
Appendix –II
Check List
Non Drawl Certificate
Dependent certificate
PPO copy(if pensioner)
Death certificate and family member certificate (if employee death)

# Government of Andhra Pradesh
# School Education Department

From

To,
The Commissioner of School Education,
Ibrahimpatnam, Vijayawada,
Andhra Pradesh, Amaravathi.

Lr. No: …… …….., Dated :……...

Sir/Madam,

Sub: Submission of MR Bills of …….
Request for scrutiny and sanctioning of admissible amount - Reg.

*****

The details of Medical Reimbursement bills submitted to you for scrutiny and sanctioning of admissible amount as per the existing G.O's are as follows:

Name of the beneficiary (Patient) :-
Name of the Employee/Pensioner:-
Relation with beneficiary :-
Claim submitted by :-

| Name | Relation with Employee/Pensioner |
|---|---|
| | |

Name of the Hospital :-
Whether approved by DME or not:- Yes ○ No ○
Date of Admission: DD/MM/YY ☐☐/☐☐/☐☐
Date of Discharge: DD/MM/YY ☐☐/☐☐/☐☐

Amount Claimed :- Rs……

*I certify that I have physically verified the following documents submitted by the Employee/Pensioner and found correct. I also certified that the original bills are kept under my safe custody until the sanction of the bill and when ever asked I will submit the original bills to O/o CSE, AP, Amaravathi.*

- ☐ *Appendix-II*
- ☐ *Non-drawl Certificate*
- ☐ *Dependent certificate*
- ☐ *Emergency certificate*
- ☐ *Essentiality certificate*
- ☐ *IP/OP Bills*
- ☐ *Consolidated IP/OP Bills*
- ☐ *Original discharge summary/Death summary (in case of death of the Beneficiary during treatment.)*
- ☐ *Copy of DME approved proceedings (in case of approved hospital)*
- ☐ *Pension payment order in case of pensioners*
- ☐ *Any other relevant documents*

Station: Signature of DDO with seal
Date:

## NON DRAWL CERTIFICATE

## (service employees)

(As per instructions issued in C & DSE, A.P., Hyderabad Procs. Rc.No. 8878/D3-4/2009, dated: 02-09-2009)

This is to certify that, the amount of Rs._____=00 (Rupees (Rupees_____ only) is being claimed now in this bill by SRI._____ , SGT/School Assistant ( ),_____,_____ Mandal, _____ District has not been paid previously towards Medical Reimbursement in respect of SRI._____ 0 (Self/ dependent), age (___) who has undergone the Treatment for the disease_____ during the period from_____to_____ in the Recognized Hospital By the Andhra Pradesh State Government i.e., at_____(hospital) as per the records available regarding the Medical Reimbursement defined under the Government Medical Attendance Rules, 1972

A note to that effect has also been made in the records of the school.

Signature of the
Government Servant.

Signature of the
Drawing & Disbursing Officer.

## NON – DRAWAL CERTIFICATE OF THE APPLICANT

## (PENSIONERS)

. . .

I, Mr./Mrs. _____
(Surname & Name)

Retired _____
(Designation, School Name, Village, Mandal and District)

_____

Receiving the Family/Service Pension vide P.P.O.No. _____ and

_____
(SB A/c. No. Bank Name, Branch Name and Mandal/Town/City, IFCI Code)

_____

Is hereby declare that, I am not claimed previously the amount of Rs. _____

(Rupees _____Only)

From the department towards the reimbursement of medical expenditure incurred for

_____treatment (or) the treatment of my Spouse/Child/Parent _____

_____ for recovery
(Name and age)

of _____
(Disease)

During the period from _____ to _____

at _____ and not received any
(Hospital Name & Address)

Part of the above amount so far.

Further, I declare that, it is a First/Second/Third ( ) Claim during my entire service and after retirement period.

Station :

Date:

Signature:
Full Name:
Residential Address:
Contact Phone No:

Certified that the amount of Rs. _____ (Rupees _____ _____ Only) furnished by the applicant in the above declaration has not been drawn from STO/DTO/PAO _____ (Dist) _____ and disbursed to him/her as per available records of this office and also with reference to the records of the Treasury Office.

Station:

Signature of the DDO with seal.

Date:

DDO Code at Treasury Office:
Treasury Office Code:

Post Address of the Office/School:-

## APPENDIX-II

## APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE & OR TREATMENT OF GOVERNMENT SERVANT

| | | | |
|---|---|---|---|
| **1.** | Name & Designation of the Government Servant/Retired (in block letters) | : | |
| **2.** | Office in which employed | : | |
| **3.** | Pay of the Government Servant as defined in FRs and other emoluments which should be shown separately | : | |
| **4.** | Place o Duty | : | |
| **5.** | Full Residential Address with Door.No. & Name of the Mohalla | : | |
| **6.** | Name of the Patient & his/her Relationship to the Government Servant. In case of children state age also | : | |
| **7.** | Place at which the patient fell ill | : | |
| **8.** | Nature of illness and its duration | : | |
| **9.** | Details of amount claimed cost of Medicines purchased from the Market/List of medicines, cash Memos and the Essentiality Certificate should be attached Each in Duplicate Signed by Treatment Doctor | : | |
| **10.** | Total amount Claimed | : | |
| **11.** | List of enclosures | : | |

## DECLARATION BY THE GOVERNMENT SERVANT

I Hereby Declare That The Contents In This Application Are True To The Best of my knowledge and belief and that the medical expenses are incurred for self as defined under the Andhra Pradesh Government Medical Attendance Rules 1972 and wholly dependent upon me

**SIGNATURE OF THE GOVERNMENT SERVANT**

**SIGNATURE OF THE FORWARDING AUTHORITY AND STAMP**

# MEDICAL REIMBURSEMENT FORM

| Employee Details | | |
|---|---|---|
| **Emp Type**: | **Emp Id**: | **Name**: |
| **Email**: | **Mobile Number**: | **Employee Designation**: |

| Address Details | | |
|---|---|---|
| **Residential Address:** | | |
| **House No**: | **Street No**: | **State**: |
| **District**: | **Villages/Cities/Towns**: | |
| **Office Address**: | | |
| **House No**: | **Street No**: | **State**: |
| **District**: | **Villages/Cities/Towns**: | |

| Employee Pay Details | | |
|---|---|---|
| **Pay Source**: | **PRC**: | **State**: |

| POSTING DETAILS | | |
|---|---|---|
| **HOD Name**: | **DDO Code**: | **District**: |

| Treatment Details | | |
|---|---|---|
| **Treatments For**: | **Patient Name**: | **Patient Gender**: |
| **Patient Date Of Birth**: | **Age**: | **Relation With Employee**: |
| **Hospital Name**: | **Hospital State**: | **Hospital Distric**: |
| **Date Of Admission**: | **Date Of Discharge**: | **Total Amount Claimed**: |
| **Is Hypertensive**: | **Is Diabetic**: | |

## Declaration

I hereby declare that the statement in the application is true to the best of my knowledge and belief and that the person from whom medical expenses were incurred is a member of my family as defined under the Government servant Medical attendance rules 1972 and wholly dependent upon me.

Signature of DDO

with Office Seal

Signature of Employee/Pensioner

## 3) THE DDO IS INSTRUCTED TO SUBMIT THE FOLLOWING DOCUMENTS .

| | | |
|---|---|---|
| i. | Emergency Certificate issued by the Hospital/ Referral letter from the teaching hospital concerned. | Issued by hospital |
| ii. | Essentiality Certificate issued by the Hospital concerned | Issued by hospital |
| iii. | Discharge Summary record / Death Summary record | Issued by hospital |
| iv. | Medical Bills | Issued by hospital |
| v. | I.P Final Bill | Issued by hospital |
| vi. | He / She has undergone treatment in recognized hospital vide DME Procs. No. | Issued by hospital |
| vii. | The Application of the incumbent in Appendix II | print |
| Viii | Check list | print |
| Ix | Non drawl certificate (service) | print |
| X | Non drawl certificate (pensioner) | print |
| Xi | Dependent certificate in respect of parents | print |
| xii | P.P.O.Copy all pages | |
| xiii | Death and family members certificate, Legal Hair Certificate, NOC certificate | Issued by concerned MRO and Municipality officers |

**NOTE :-**

SUBMIT THE PROPOSALS ABOVE RS 50,000/- BILLS TO THE COMMISSIONER OF SCHOOL EDUCATION,A.P,IBRAHIMPATNAM VIJAYAWADA AMARAVATHI THROUGH DDO(DYEO/MPDO/MEO/HM) CONCERNED.

# ESSENTIALITY CERTIFICATE

I Certify that Mrs. / Mr. / Miss …… … Wife / Son /Daughter of Mr/Mrs…… employed in the …… has been under my treatment for …….. diseases from ……to …… at ……..Hospital / my consulting room and that the under mentioned medicine prescribed by me in this connection were essential for the recovery / prevention of serious deterioration the condition of the patient . The Medicines are not stocked in the ……Hospital ( for supply to patients) and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available or preparations which are primarily foods, toilets of disinfectants.

| **Name of Medicines** | **Price** |
|---|---|
| ……. | …… |
| …… | …… |
| …… | …… |

**Signature and Designation of Authorized Medical Attendant**
**Signature of the Medical Officer in charge in the case of the hospital**

**EMERGENCY ADMISSION CERTIFICATE**

This is to certify that Mr. / Mrs./Ms…… S/o. D/o/ W/o……aged about ……admitted in our hospital in ……Department under emergency on …… at ……. am / pm.

The provisional diagnosis is ……..

**Signature and designation of the attending medical authority**

## CERTIFICATE – A

**(To be completed in the case of patients who are not admitted to hospital for treatment for the following cases only along with ORIGINAL OUT PATIENT (OP) SLIP FROM CONCERNED DOCTOR)**
(Chemotherapy, Radiotherapy for cancer, Regular dialysis for Kidney, Cardinal cases like cardiac cases, Severe neurological problems and A.I.Ds subject)

1. I Dr. …… hereby certify

a) That I charged Rs. …… for ……. consultation on…….. at my consultation room / at the residence of the patient.

b) That I charged Rs. …… for administering intramuscular/ intravenous / subcutaneous injections on……. (Dose to be given) ay my consulting room at the residence of the patient

c) That injections administrated repay in formatting or propyloction purpose.

d) That the patient has been under treatment at …….hospital consulting room and that the under mentioned 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 ……hospital and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available or preparations which are primarily foods, tonics, toilets or disinfectants.

| **Name of the Medicine** | **Cost** |
|---|---|
| ……..... | …… |
| ……..... | …… |
| ……..... | …… |

e) That patient is / was suffering from ……
And is / was under my treatment from ……

f) That the patient was / not given prentation post treatment

g) That the X ray, Laboratory tests etc, for which an expenditure of Rs. …… was incurred was necessary and was under taken on my active at the ……. (name of the hospital or laboratory .

h) That referred the patient of Dr……for specialist multilation and that the necessary approval of Director , Medical Service as required under the rules was obtained and

i) That the patient did not require / required hospital etc.

**Date ……..** **Signature and Designation of the Authorized Medical Attendance**

## CHECK SLIPS FOR SENDING MEDICAL REIMBURSMENT PROPOSALS

| | | | |
|---|---|---|---|
| 1. | Name and Official Address of the teacher | : | |
| 2 | If Retired<br>a) Date/Year of Retirement<br>b) Designation<br>c) P.P.No. | : | |
| 3. | Communication of Applicant, Address for all purpose with Phone No. | : | |
| 4. | Name & Address of the Hospital & Dates of Treatment<br>a) Whether it is Private Hospital (or) Recognized Hospital<br>b) Whether referral letter produced (or) Recognized orders to be enclosed alongwith proposal. | :<br>: | YES / NO<br>YES / NO |
| 5. | Whether the Medical Reimbursement Proposal is received in the Head Office within a period of Six Months from the date of discharge. | : | |
| 6. | Whether the following are enclosed or not | : | |
| 1) | Appendix-II duly attested by the forwarding authority. | : | YES / NO |
| 2) | Non-Drawal Certificate in Prescribed Proforma | : | YES / NO |
| 3) | In case Retired complete set of Pension Payment Order copy duly attested by the forwarding authority | : | YES / NO |
| 4) | Emergency Certificate | : | YES / NO |
| 5) | Essentiality Certificate | : | YES / NO |
| 6) | Discharge Summary | : | YES / NO |
| 7) | In case Dependent: Dependent Certificate | : | YES / NO |
| 7. | If the patient is dependent on the Govt Employee in case of dependents above the age of 18 years Un-Employee Certificate and Marital Status of dependent are to be enclosed with Medical Reimbursement Proposal | : | YES / NO |
| 8. | In case of the dependent of deceased Govt. Employee / Retired Employee whether Death & Legal Heir certificate enclosed or not | : | YES / NO |
| 9. | Whether the Medical Reimbursement Proposal is prepared & submitted with reference to G.O.Ms.No. 74 HM & FW (K1) Dept, dt: 15.03.2005 & G.O.Ms.No. 60 HM & FW (K1) Dept, dt: 15.10.2003, & G.O.Ms.No. 105 HM & FW (K1) Dept, dt: 09.04.2007, G.O.Ms.No. 180 HM & FW (K1) Dept, dt: 11.05.2006. | : | YES / NO |
| 10 | Whether the Medical Reimbursement claim in processed through the drawing officer and received within the stipulated time. | : | YES / NO |
| 11 | And whether the availament of No. of installments recorded (or) not | : | YES / NO |
| 12 | Whether an entry is made in the service Register (or) not for previous claim and drawal. | : | YES / NO |

I _____ (Full Name & Designation) here be declare that my Father/Mother/Son/Daughter _____ has no properly or income of his/her own and that he/she is wholly dependent on me as per APIMA Rules 1972.

**Signature of the Government Servant** **Signature of Forwarding Authority**

## DEPENDENT CERTIFICATE GIVEN BY THE GOVERNMENT SERVANT

(As per instructions issued in C & DSE, A.P., Hyderabad Procs. Rc.No. 8878/D3-4/2009, dated: 02-09-2009)

I, SRI._____ _SGT/, School Assistant ( ),_____School_____Mandal,_____ District, do hereby declare that, My Dependent of Sri_____., age ( ) Years is my **Son/Daughter/mother/father/husband** and has no property of income of his own and that, he/she is wholly dependent on me only, he is also not a Employee or Pensioner.

Signature of the
Government Servant.

Signature of the
Drawing & Disbursing Officer.

# SCRUTINY OF MEDICAL BILLS – DOCUMENTS REQUIRED

**For scrutinizing of medical bills at Directorate of Medical Education, Government of Andhra Pradesh, the following original documents/ certificates/letters should be submitted along with the claims.**

**Xerox copies will not be accepted**

**Government Employees/ Pensioners – Please show your Employee / Pensioners ID card at the hospital at the time of admission**

**DOCUMENTS/LETTERS**

1. Forwarding Letter
2. Application Requisition of individual with date
3. Check list duly attested by the Forwarding Officer
4. Appendix-II duly signed by the Employee/Pensioner and attested by the Forwarding Officer
5. Non-Drawal Certificate in Prescribed proforma
6. Dependent Certificate as required in prescribed proforma with Forwarding Officer signature
7. P.P.O.(Pension Payment Order) copy in case of pensioner/family pensioner attested by the Forwarding Authority
8. In case of accident cases and treatment taken in un-recognized hospitals under emergency, FIR should be submitted
9. For every follow up treatment for post operative cases and who requires lifelong treatments, revalidation of prescription once in six month from special government doctor attested by Forwarding Officer
10. Legal Heir Certificate should be submitted in case of death of the Teachers/Pensioners/Dependents duly attested by the Forwarding Authority
11. A copy of proceedings Issued by the Director of Medical Education for recognition of the hospital
12. Emergency Certificate/O.P in original duly signed and stamped by the treating doctor attested by Forwarding Officer
13. Essentiality Certificate in original duly signed and stamped by the treating doctor attested by Forwarding Officer
14. Discharge Summery/Discharge Memo.(OP card in respect of OP treatment) in original duly signed and stamped by the treating Doctor attested by Forwarding Officer
15. Abstract of Bills (All original Medical Bills should be signed with stamp by the treating Doctor) attested by Forwarding Officer.
16. Details proposal along with justification/need in case of claims where relaxation of rules in involved

**The concerned Forwarding Authorities/ Drawing and Disbursement Officers are personally held responsible for fake and fabricated bills and misappropriation of public funds.**