Dash Board Services Medical Reimbursement Reports Others Logout

iginal Bills, Proformae and Online application Print to your MEO/HM

Medical Reimbursement - Claim Registration Form

Employee Name	G VIJAYA BHARATHI

*All Fields Are Mandatory

School Details			
District Name	Guntur	Mandal Name	EDLAPADU
Village Name	THIMMAPURAM	School Name	28173700904-ZPHS TIMMAPURAM
Personal Details			
Treasury Code	0619231	Name of the Employee	G VIJAYA BHARATHI
Gender	Female	Date Of Birth (DD/MM/YYYY)	14/12/1963
Designation	---Select---	Mobile Number	9949707504
Aadhaar Number	639661658973	ATO/STO/PAO Name	
Employee Address Details			
House Number		Street Name	
District Name	---Select---	Mandal Name	---Select---
Village Name	---Select---	Pincode	
Patient Details			
Relationship with Employee	--Select--	Name of the Patient	
Nature of Disease/Illness/Treatment		InPatient Number	
Date of Admission (DD/MM/YYYY)		Date of Discharge (DD/MM/YYYY)	
In case of death, during the treatment	--Select--	Total Amount claimed(Rs.)	
Hospital details			
Hospital District Name	---Select---	Hospital Names	---Select---
Date Of recognition from(DD/MM/YYYY)		Date Of recognition to(DD/MM/YYYY)	

Documents (Proof in support of claim)

Bill number	Bill date (DD/MM/YYYY)
	DD/MM/YYYY

Discharge summary PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen	Essentiality Certificate PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen
Emergency Certificate PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen	Dependent Certificate PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen

Submit

Designed, Developed & Maintained by APOnline

NEW! NOTE 1 : Submit Original Bills, Pr

Retired Employees - Claim Registration Form

*All Fields Are Mandatory

Personal details			
PPO ID		Name of the employee	
Gender	--Select--	Date Of birth (DD/MM/YYYY)	
Designation	---Select---	Mobile number	
Aadhaar number		ATO/STO/PAO Name	
PPO NUMBER			
Employee Address Details			
House number		Street name	
District name	---Select---	Mandal name	---Select---
Village name	---Select---	School name	---Select---
Pincode			
Bank details			
Bank name	---Select---	Bank branch	---Select---
IFSC code		Account no.	
Account holder name			
Patient Details			
Relationship with employee	--Select--	Name of the patient	
Nature of Disease/Illness/Treatment		In-Patient number	
Date of admission (DD/MM/YYYY)		Date of discharge (DD/MM/YYYY)	
In case of death, during the treatment	--Select--	Total amount claimed(Rs.)	
Hospital details			
Hospital District Name	---Select---	Hospital Names	---Select---
Date of recognition from(DD/MM/YYYY)		Date of recognition to(DD/MM/YYYY)	
Documents (Proof in support of claim)			
Bill Number		Bill date (DD/MM/YYYY)	
		DD/MM/YYYY	
Discharge summary PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen	Essentiality Certificate PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen
Emergency Certificate PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen	PPO COPY PDF (PDF SIZE 6KB to 1MB)	Choose File No file chosen
Submit			

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)

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:

Date:

Signature of the DDO with seal.

DDO Code at Treasury Office:
Treasury Office Code:

Post Address of the Office/School:-

CHECK SLIPS FOR SENDING MEDICAL REIMBURSMENT PROPOSALS

1.	Name and Official Address of the teacher	:	
2	If Retired a) Date/Year of Retirement b) Designation c) P.P.No.	:	
3.	Communication of Applicant, Address for all purpose with Phone No.	:	
4.	Name & Address of the Hospital & Dates of Treatment a) Whether it is Private Hospital (or) Recognized Hospital b) Whether referral letter produced (or) Recognized orders to be enclosed alongwith proposal.	: :	YES / NO 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**

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.

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.

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