Gautam Buddha University

Gautam Buddha Nagar

Greater Noida

FORM OF APPLICATION FOR MEDICAL CLAIMS:

1. Name & Designation of Government Servant   :
    (in Block Letters)

    (i)   whether married or unmarried   :

    (ii)   if married, the place where   :
            wife/husband is employed

2. Office in which employed   :

3. Pay of the Government servant as defined in the   :
    Fundamental Rules and any other emoluments
    which should be shown separately

4. Place of duty   :

5. Actual residential address   :

6. Name of patient and his/her relationship to the   :
    Government servant
    N.B. – In the case of children state age also

7. Place at which the patient fell ill   :

8. Details of the amount claimed

    I.   Medical Attendance
    (i)   Fees for consultation indicating-   :
    (a)   the name and designation of the
           medical officer consulted and the
           hospital or dispensary to which
           attached

    (b)   the number and dates of consultation   :
           and the fee paid for each consultation

    (c)   the number and dates of injection and   :
           the fee paid for each injection

    (d)   whether consultation and/or injection   :
           were had at the hospital, at the
           consulting room of the Medical Officer
           or at residence of the patient

(ii) **Charges for Pathological,** : **bacteriological, Radiological or other similar tests undertaken during diagnosis indicating –**

(a) The name of the hospital or laboratory :
where undertaken; and

(b) Whether the tests were undertaken on :
the advice of the Authorized Medical
Attendant. If so, a certificate to that
Effect should be attached

(c) Cost of medicines purchased from the :
market
(Cash memos and the Essentiality
Certificates should be attached)

9. Total amount claimed :

10. Less advance taken if any :

11. Net amount claimed :

12. List of enclosures :

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

I hereby declare that the statements in the 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.

**Signature of the Government Servant
and Office to which attached**

Date : ....

Place: ....