

**Medical Claim Form for IP (Certificate-B)**

(To be filled in the case of a patient admitted to the hospital for treatment)

Please fill in all the fields. The incomplete form shall not be entertained

**PART - A**

**Employee Particulars:**

Name			
Designation		ID No.	

I Certified that the treatment has taken for the following person.

Patient Name			
Age		Relationship with the Employee	

S.No.	Date	Bill / Receipt No.	Amount

# Please use a separate sheet if necessary.

**Travel Expenditure:**

I hereby declare that I have used (Own vehicle/Hired vehicle/Public transport) for travel, details are given below:

S.No.	Date	Invoice No/ Own vehicle Reg.No.	From	To	Amount

# Please use a separate sheet if necessary.

**Total Claim Rs.** \_\_\_\_\_.

(In words: \_\_\_\_\_).

# Advance if any availed Yes/No. If yes, amount Rs. \_\_\_\_\_.

No. of Enclosures (Excluding Claim Form) \_\_\_\_\_.

**I Certify:**

- a) that I or my wife/husband has not claimed this reimbursement from any other source and will not claim the same in the future.
- b) that the patient was admitted to hospital on the advice of (Name of the Medical Officer / AMA / Competent Authority / \*Emergency). \_\_\_\_\_ on \_\_\_\_\_.
- c) that the Dr. \_\_\_\_\_ has given treatment at \_\_\_\_\_ hospital.
- d) that the patient is/was suffered/treated for \_\_\_\_\_, and is/was under treatment from \_\_\_\_\_ to \_\_\_\_\_.
- e) that the medicines prescribed by the above doctor in this connection were essential for the recovery/prevention of serious deterioration of the condition of the patient. and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available or preparations that are primarily foods, toilets or disinfectants.
- f) that the injections administered are/were not for immunizing or prophylactic purposes.
- g) that the X-Ray, Laboratory tests, etc., for which an expenditure was incurred were necessary and were undertaken on above doctor's advice at \_\_\_\_\_ (name of hospital or laboratory).

Date of Submission :

Signature of the Employee

**Note:** Claim should be submitted within 6 months from the date of completion of treatment.

**Documents to be enclosed:**

- (1) Self-attested photocopy of the Prescriptions and Discharge Summary.
- (2) Original Bills and Receipts.
- (3) Approval copy of the Institute Medical Officer/Dean Admin/Director.
- \*(4) Original Emergency Certificate (In case of emergency),
- (5) Investigation reports (if they are not part of CGHS).

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**PART – B (Optional)**

I certify that patient has been under treatment at the \_\_\_\_\_ hospital and that the service of the special nurses for which an expenditure of Rs. \_\_\_\_\_ was incurred, vide bills and receipt 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