



PROFORMA FOR MEDICLAIM

1. Name of the Institute Employee :.....
2. Designation of Employee :.....
3. Basic Pay of the Employee :.....
4. Residential Address :.....
5. Name of the Patient and
His / her relationship to the Employee :.....
N.B. – In the case of children state age also.
6. Place at which patient fell ill :.....
7. Details of the amounts 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 fee paid for each consultation :.....
- (c) The number and dates of injection and the fee paid for each injection :.....
- (d) Whether consultations and/or injections were had at the hospital, at the consulting room of the Medical Officer or at the residence of he 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. :.....



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

.....

8. Total amount claimed Rs.

9. Less advance taken Rs.

10. Less amount claimed Rs.

11. List of enclosures :.....

DECLARATION TO BE SIGNED BY THE INSTITUTE EMPLOYEE

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 Employee

Date:.....



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ESSENTIALITY CERTIFICATES

CETIFICATE 'A'

(To be completed in the case of patients who are not admitted to hospital for treatment)

Certificate granted to Mr./Mrs./Miss.....
wife/son/daughter of Mr.....employed in the Indian Institute of
Information Technology and Management Gwalior (M.P.)

I Dr.hereby certify:-

- (a) That I charged and received Rs.For.....consultations
on.....(dates to be given) at my consulting room / at the residence of the patient;
- (b) That I charged and received Rs.for administering.....
intravenous/intra-muscular/subcutaneous injections on.....(dates to
be given) at.....my consulting room / the residence of the patient;
- (c) That the injections administered were not / were for immunizing or prophylactic purpose;
- (d) That the patient has been under treatment at.....hospital / my
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.....(name of hospital) for
supply to private patient and do not include proprietary preparations for which cheaper substances
of equal therapeutic value are available nor preparations which are primarily foods, toilets or
disinfectants.

P.T.O.



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S.No.	Name of Medicines	Quantity	Price
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

- ⇒
- (e) That the patient (.....) is / was suffering from.....and is / was under my treatment from.....to.....;
- (f) That the patient is / was not given pre-natal or post-natal treatments;
- (g) That the X-ray, laboratory test, etc., for which an expenditure of Rs.....was incurred was necessary and were undertaken on my advice at (name of the hospital or laboratory);
- (h) That I referred the patient to Dr.for specialist consultation and that the necessary approval of the(name of the Chief Administrative Officer of the State) as required under the rules was obtained.
- (i) That the patient did not require / required hospitalization.

Signature of AMA / Designation of

⇒
The Medical Officer and hospital
Dispensary to which attached.

Dated.....

N.B. – Certificates not applicable should be struck off. Certificate(s) is compulsory and must be filled in by the Medical Officer in all cases.