Medical reimbursement to Staff (OPD) : 230110O079
Department Code : 0110

FORM GAU – 27 (A)

BIRLA INSTITUTE OF TECHNOLOGY AND SCIENCE-PILANI
HYDERABAD CAMPUS

FORM FOR TREATMENT BY MEDICAL OFFICER AT INSTITUTE
HOSPITAL OR OTHERWISE

Certificate granted to Mrs./Mr./Miss _____

Wife/Husband/Son/Daughter/Mother/Father of Mr./Dr. _____ PSRN

_____ employed in the _____ (Division / Unit).

ESSENTIALITY CERTIFICATE A

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

I, Dr._____hereby certify:-

(a) that the injections administered are not for immunizing or prophylactic purpose;

(b) that the patient has been under treatment at the _____ Hospital / my consulting room and that the undermentioned medicines prescribed by me in this connection were essential for the recovery / prevention of serious deterioration in the condition of patient. The medicines are not stocked in the _____ Hospital for supply to private patients 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:-

S.No	Name of Medicine	Price
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

(c) that the patient is / was suffering from _____ and is / was under my treatment from _____ to _____;

(d) that the X-Ray, laboratory tests, etc., for which the expenditure of Rs. _____ was incurred were necessary and were undertaken on my advice at the _____ Hospital ;

(e) that the patient is / was not given pre-natal / post-natal treatment;

(f) that I referred the patient to Dr._____ for specialist consultation; and

(g) that the patient did not require / required hospitalization.

Date: _____ Medical Officer-in-Charge

N.B: Certificate not applicable should be struck off. Certificate (c) is compulsory and must be filled in by the Medical officer in all cases.

C

BIRLA INSTITUTE OF TECHNOLOGY AND SCIENCE-PILANI
HYDERABAD CAMPUS

Application for claiming refund of Medical expenses incurred in connection with Medical attendance and/or Treatment of the members of the Birla Institute of Technology and Science and their families.

N.B. Separate form should be used for each patient.

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1. Name of Designation of Claimant (in block letters)
   Name : _____
   PSRN : _____
   Designation : _____

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2. Office in which employed _____
   Division / Unit / Office, BITS, Pilani, Hyderabad Campus

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3. Pay as defined in rules and other emoluments Which should be shown separately.
   Rs. _____ p.m.

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4. Place of duty

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5. Actual residential address

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6. Name and age of the patient and his/her relationship to the member of the staff.
   Name : _____
   Relation : _____

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7. Place at which the patient fell ill

_____

8. Nature of illness and its duration.
   Nature of illness _____
   Duration: From _____to_____

DETAILS OF THE AMOUNT CLAIMED

i. Fee 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 consultations and the fee paid for each consultation.
   (c) Whether consultations were had at hospital, at the consulting room of the Medical officer or the 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 the tests were undertaken, and
   (b) Whether tests were undertaken, on the advice of the authorized Medical attendant. If so, certificate to that effect should be attached.

iii.	Cost of medicines purchased from the market (List of medicines, cash memos and prescription should be attached)	Rs. _____
9.	Total amount claimed	Rs.
10.	List of enclosures: Cash Memos : Pres : Total :	

DECLARATION TO BE SIGNED BY THE MEMBERS OF THE STAFF

I hereby declare that the statements in this 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 and is not an earning member of the family.

Signature of the Member of the Staff

Date:_____

Forwarded

Signature of the Controlling Officer

Budget Officer

Please verify as per rules amended up-to-date and pay 90 percent of the admissible claim.

Countersigned and certified that the claim:-

(i) is genuine,
(ii) is covered by the rules and orders on the subject,
(iii) is supported by bills, receipts and other certificates, etc.
(iv) was not drawn before, and
(v) has been sanctioned by me

Dean, Administration
Birla Institute of Technology and Science, Pilani
Hyderabad Campus