TRANSMISSION CORPORATION OF TELANGANA LIMITED

Claim for Reimbursement of Medical Charges For Out-Patient Treatment
(Check List to be signed and furnished by the Board Employee)

Indicate 'Yes' or 'No' In the Brackets against each item.

1. All the Columns of the application form have been filled in properly ( )

2. The bill has been submitted along with Essentiality Certificate 'A' for the treatment as Out-Patient by Furnishing all the particulars and signed by the Medical Attendant who treated the Patient. ( )

3. The bill has been submitted along with the Essentiality certificates 'B' for the treatment as In-patient by furnishing all the particulars and signed by the Medical Attendant who treated the patient and countersigned by the Head of the Hospital. ( )

4. The name of the disease has been indicated in the essentiality certificate in Block letters. ( )

5. The period of Treatment has been specifically indicated in the essentiality certificate. ( )

6. The case Doctor has signed on the essentiality certificate and countersigned by the Head of the Hospital (with stamp). ( )

7. All the Columns of Essentiality Certificate 'A'/'B' have been filled in PROPERLY. ( )

8. All the cash receipts are within the period of treatment. ( )

9. The cash receipts have been countersigned by the Doctor (with stamp) who treated the patient. ( )

10. The name of the patient and name of the Doctor has been indicated in all the cash receipts. ( )

11. All the cash receipts enclosed to the Medical Reimbursement claim are dated. ( )

12. The total amount of cash receipts tallied with the amount claimed. ( )

13. The duplicate bill with the copies of the Original bills has been submitted ( )

14. All the Cash receipts enclosed to the Medical Reimbursement application ( )

has to be signed by the employee declaring as "paid by me".

(SIGNATURE OF THE EMPLOYEE)

Certificate to be furnished by the Forwarding Officer

1. The bill is submitted within three months from the date of completion of treatment.

2. The application is as prescribed by the Board.

3. The application form has been signed by the employee/countersigned by the controlling Officer with dates.

4. The name of the disease is indicated in Block letters in the essentiality certificate certifying that it is a Chronic Disease.

5. The Medical Bill of the employee has been thoroughly scrutinized in the light of the instructions and guide lines issued in para 14 of Boards Memo. No.DP/ DM(A) F3/2487/85-16, Dt. 25-4-89 and the statement is furnished.

6. The total amount of reimbursement so far sanctioned to the employee is Rs…….

7. Prior permission from the competent authority for taking treatment outside the state has been obtained in Memo.No……Date……..

8. The claim is within the powers of JMD (HRD,Comml,IPC & Reforms) as per B.P.Ms.No.238, Dt. 13-12-1995 & TOO.Ms.No.144, dt.22-9-2004.

9. Amount so far availed Rs……in spells.

   1.
   2.
   3.
   4.
   5.

Signature of the claimant

ATTESTATION OF THE
FORWARDING OFFICER
(with stamp)

Contact Phone Nos. Res. :
Office :

FORM OF APPLICATION FOR MEDICAL CLAIMS
(for Out-Patient Treatment)

1. Name of the Employee. :

2. Date of Birth. :

3. Designation and Basic pay :

4. Section and office in which employed :

5. Employee I.D. No./ PPO.No. if Retired :

6. Place of retirement (Pensioners) :

7. Present Office address :

8. Actual Residential Address. :

9. Office and place where Wife/Husband is Employed (if both are employed) :

10. Name of the patient and relationship (In case of children state age also with age proof) :

11. Name of the Medical Attendant and Address and Name of the Hospital. :

12. Name of the disease in block letters. :

13. Period of treatment as in patient/ Out patient as indicated in the Certificate. :

14. Details of medical charges incurred Medical attendance:-
    a) The No. and dates of consultations and fees paid for each consultation. :

    b) The No. and dates of injections and Fees paid for each injection. :

    c) Details of Laboratory tests (X-Ray Charges etc.) :

    d) Cost of Medicines (Details of the Consolidated medicines shall be furnished in the essentiality certificate) :

15. Hospital Treatment:
    a) Accommodation Charges. :

    b) Diet Charges. :

    c) Lab charges (details shall be furnished) :

Contd.....2

d) Surgeons fee. :

e) Asst. Surgeon's fee :

f) Anesthetist fee :

g) Theatre charges :

h) Nursing charges :

i) Blood charges :

16 Total amount claimed :

17. Less advance taken on :

18. Net amount claimed :

19. No. of enclosures. :

Declaration to be signed by the Employee

I hereby declare that the statements furnished above are true to the best of my knowledge and belief and the person for whom the above medical expenses were incurred is wholly dependent on me.

Place :
Date :

SIGNATURE OF THE EMPLOYEE

Countersigned and forwarded/submitted to _____ for necessary action.

(SIGNATURE OF THE CONTROLLING OFFICER)
(With date, designation and stamp)

Note:-The claim shall be supported by Essentiality certificate and cash receipts of the expenses shall be countersigned by Doctor/Medical Officer.

All the cash receipts shall be within the period of treatment as indicated in the essentiality certificate. They must necessarily contain the name of the patient, name of doctor and date of issue.

The claim of the employees other than those opted for treatment at the Dispensary of Vidyut Soudha shall be only for chronic diseases like T.B. or other major operations and the same shall be indicated by the Doctor in the essentiality certificate.

All the medical bills shall be submitted to their controlling Officers within three months from the last date of the treatment period/from the date of the bill who in turn after scrutiny, forward to the sanctioning authority as per the powers delegated in B.P.Ms.No.238, Dt. 13-12-1995 so as to enable this office to sanction the amount immediately

Contd……3

ESSENTIALITY CERTIFICATE - A

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

Certificate granted to Mrs, Mr./Miss _____

Wife / Son / daughter of Mrs. / Mr. _____

Employed in the office of the _____

I, Dr. _____hereby Certify

(a) That I charges and received Rs._____for_____ Consultation on _____at my consulting room/at the residence of the patient.

(b) That I charged and received Rs._____for administering injections on _____at my consulting room/at the residence of the patient.

(c) That the injections administered were not immunizing or prophylactic purposes.

(d) That the patient has been under treatment at_____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 the patient. The medicines were not stocked in the _____(name of the hospital) for supply to private patients and do not include proprietary preparation for which cheaper substances of equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

S.No	Name of the Medicine	Price	S.No	Name of the Medicine	Price
			Total Rs.		

(e) that the patient is/was suffering from _____ which is chronic/not chronic/major operation/minor operation) and as in-patient and from _____ to _____as out patient.

(f) That the patient is/was not given pre-natal treatment.

(g) that the X-ray laboratory tests etc, for which an expenditure of Rs._____ was incurred were necessary and were undertaken on my advice at _____.

(h) That I referred the patient to Dr._____ for specialists consultation and that the necessary approval of the _____ as required under the Rules was obtained.

(i) That the patient did not require/required hospitalization.

Signature and Designation of the
Medical Officer incharge of the case
at the Hospital (with stamp)

Contd.....4

PART –B

I certify that the patient has been under treatment at _____ Hospital and that the service of the special nurses for which an expenditure of Rs._____ was incurred vide bills and Receipts attached were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer
Incharge of the case of the Hospital
(with stamp)

COUNTERSIGNED
Medical Superintendent

_____Hospital.

I certify that the patient has been under treatment at _____ Hospital and that the facilities provided were the minimum which were essential for the patient treatment.

Place:

MEDICAL SUPERINTENDANT

Date: (with stamp)

Note: Certificates not applicable should be struck off.
Certificate (d) is compulsory and must be filled in by the Medical Officer in all the cases. The name of the disease shall be followed by the word 'Chronic'/ Major operation for reimbursement of Medical charges as per Regulation 4(f) of the A.P.S.E.B Regulations for Reimbursement of Medical charges. The list of consolidated medicines shall be furnished in Block Letters.

The minimum facilities certificate may be signed either by the Medical Superintendent of the Hospital concerned or another Gazetted Medical Officer who has been authorized in this behalf by the Medical Superintendent.