ESSENTIALITY CERTIFICATE

(To be filled In Capital letters)

Name of Claimant…….. Period of Treatment……..
Designation …….. From ……TO ……
Department ……Indoor No ……. Date…….
Pay:BASIC-Rs…… Outdoor No…… Dt…….

I certify that Mr/Mrs: …… S/D/Wife of Mr……
employed in the office of the……..
has been under my treatment in the ……..
……..
Hospital / dispensary in my consultation and that the under mentioned medicines prescribed by me…….. ……..
…….(Name of Hospital) for the supply to the patient and do not include prepartion for which cheaper substitute of equal therapeutic value are available/not the prepartion prescribed are primary food, tolet or disinfectants.

1. Certified that medicines have no cheaper and effective substitute
2. Certified that the treatment given was indoor / outdoor
3. Certified that the price claimed is reasonable
4. Certified that the medicines are not in the nature of tonics or food or vitamins etc., the cost of which is not reimbursable In the Govt. orders issued on this subject from time to time.
5. She is suffering from .....

S. No.	Name & Quantity of medicines in capital letters	Outdoor ticket No & Date on which prescribed	Date on which actually purchased with Bill No.	Price Rs. P.

Signature and Designature
of Authorized Medical attendant
Name in capital letters……..

MEDICAL RE-IMBURSEMENT FORM

In case of indoor Treatment:

Certified that the medicines claimed in this bill are as hand ticket no …… are relates to the case.

Signature & Stamp of the
Authorised Medical Attendant

Certified that:

1. The Medicines have actually been purchased by me during the course of treatment.
2. I am living in the House No. ....:.....
3. I have purchased the medicines from the prescribed co-op. store.
4. The medicines have been purchased from private shop after obtaining non availability certificate from Co-op. Store/Super Bazar .....
5. The amount of medicines purchased from private shop against one or more prescription does not exceed Rs. ..... in a single day.
6. In case of wife/children:-

That the patient Mr./Mrs**. .....** is my **.....** .and she is wholly dependent upon me and is residing with me and he/she is unmarried and un-employed (in case of son/daughters)

7. For parents only :-

his/her total monthly income does not exceed Rs. ..... P.M. any mother/father is/are residing with me.

8. In case spouse is working :-

a) Certified that my wife/husband is not getting any fixed medical allowance from any source

b) Certified that my wife/husband is employed and is not getting any medical re-imbursement. an affidavit to this effect has been furnished.

c) Certified that I a not adhoc employee and am working on regular basis.

Signature of the Claimant

Name (in capital letters)
Designation

Place_____

Date_____