KERALA STATE ELECTRICITY BOARD

APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES FOR BOARD EMPLOYEES AND THEIR FAMILIES
(Separate Form should be used for each patient vide BO No.1120/91 (Estt.VII/3191/90) dated 30.10.1991)

1. Name and Designation of Board Employee (In Block Letters) :

2. Pay & Scale of Pay :

3. Office in which employed :

4. Place of duty :

5. Residential address :

6. i. Name of patient & his/her relationship with the Board Employee :
   ii. If applicant's Wife/Husband is employed in Central/State Government or any other :
   iii. If employed, whether joint declaration of the Wife/Husband has been received and recorded in the Service Book :

7. Place at which the patient fell ill :

8. Whether hospitalised or not :

9. If hospitalised, whether in Government Hospital/Private Hospital and the name of the Hospital :

10. If hospitalised outside the State
    i. whether the patient was on duty :
    ii. Name of Institution :

11. If any special treatment outside the State
    i. Name of Institution :
    ii. Whether Certificate of Director of Health Services as contemplated in Rule 7(a) is attached. :
    iii. Whether prior sanction of Director of Health Services has been obtained :

12. i) Last date of treatment :
    ii) If the treatrnent is of continuous nature furnish the last date of treatment in respect of previous claim, if any :

13. Details of amount claimed (List of Medicines, Cash Memos and Essentiality Certificate shall be attached) :

i) Charge of Medicines :

ii) Charges of Treatment :

iii) Charges of Accommodation :

iv) Charges for Laboratory services etc.:

14. Total Amount claimed (In figures & words)

15. List of enclosures

i. Essentiality Certificates :
ii. List of Cash Bills :
iii. Certificate of Medical Officer :

DECLARATION TO BE SIGNED BY THE BOARD EMPLOYEE

1. I hereby declare that the statements given above are true to the best of my knowledge and belief and that the person for whom medical expenditure has been incurred is neither employed elsewhere nor a pensioner and is wholly dependant on me.

2. I, ...

employed in the .....

(state the name of Division/Office) declare that .....

.....(relationship)

have/has been under treatment at .....

.....

Hospital/Residence, during the period of treatment from .....

to ..... and I/he/she have/has received the benefit of one system of treatment and not taken advantage of more than one system simultaneously.

Signature:

Place:

Name &
Designation of the
Employee

Date:

ESSENTIALITY CERTIFICATE

I certify that Sri./Smt. . . . . .
employed in the . . . . . .
has been under treatment in this Hospital/Dispensary or at his /her residence for the period from . . . . . to . . . . . .
and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the conditions of the patient. They do not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparations which are primary foods, tonics, toilet preparations or disinfectants.

It is certified that the case did not require hospitalisation but is one of prolonged nature requiring medical attendance at the out-patient department spreading over a period of more than 10 days.

The patient was/has been suffering from .....

Cash Bill No. & Date	Trade/Brand Name of Medicines	Chemical/ Pharmacological Name of medicine	Description	Price

Place:
Date:

Signature:
Name & Designation of
Authorised Medical Attendant:
Name of Institution:
Register No.
Qualification:
System of Medicine:

(Office Seal)