**ICAR-INDIAN GRASSLAND AND FODDER RESEARCH INSTITUTE JHANSI – 284 003**

Form 97 APPENDIX-XIII

## Form of Application for Medical Claim

**1.** Name and Designation of Government Servant (in Block Letters) :

i) Whether married or unmarried :

ii) If, married, the place where wife/husband is employed :

**2.** Office in which employed :

**3.** Pay of the Government Servant as defined in the Fundamental Rules and any other emoluments which should be shown separately :

**4.** Place of Duty :

**5.** Actual Residential Address :

**6.** Name of the Patient and his/her relationship to the Government Servant (Age ***In the case of children)*** :

**7.** Place at which the patient fell ill :

**8.** Details of the amounts claimed :

**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 the fee paid for each consultation :

**(c)** the number and dates of injection and 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 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 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

**(iii)** Cost of medicines purchased from the market :

*(Cash memos & Essentiality Certificates should be attached)*

**9.** Total amount claimed :

**10.** Less advance taken on :

**11.** Net amount claimed :

**12.** List of enclosures: **1.** **2.**

**3.** **4.**

### DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

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.

**Date :**

**Signature of the Government Servant and Office to which attached**