

SOUTHERN RAILWAY

G.R.3 G267(old)

FORM OF APPLICATION FOR CLAIMING MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR TREATMENT OF RAILWAY SERVANTS AND THEIR FAMILIES.(Railway Board's No.E50 M.E.3/4/3 dated 21st August 1950 No. E53 M.E.1/40/3 17th dated December 1953) N.B. Separate form should be used for each patient.

1	a) Name and designation of Railway servant (in block letters)	
	b) Class	
2	Office in which employed	
3	Pay of the Railway servant as defined in the existing, 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 Railway servant (N.B. In the case of children state age also)	
7	Place at which the patient fell ill	
8.	Details of the amount claimed	
	<u>1. MEDICAL ATTENDANCE</u>	
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 fees paid for each consultation	
c)	Whether consultation were had at the hospital, at the consulting room of the Medical Officer or at the residence of the patient. Whether consultation 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 the tests were undertaken and
- b) Whether the 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** (If medicines cash memos and the essentiality certificate should be attached)

II.HOSPITAL TREATMENT(Charges for hospital treatment, indicating separately the charges for)

i) Accommodation

(State whether it was according to the status or pay if the Govt servant and in cases where the accommodation is higher than the status of the Rly. Servant, a certificate should be attached to the effect that the accommodation to which he was entitled was not available)

ii) Diet

iii) Surgical operation or medical treatment

iv)	Pathological, Bacteriological, Radiological or other similar test indicating – a) The name of the hospital or laboratory at which undertaken b) Whether undertaken on the advice of the Medical Officer in charge of the case at the Hospital. If so, a certificate to that effect should be attached.	
v)	Medicines	
vi)	Special medicines (list of medicines, cash memos, and the essentiality certificate should be attached)	
vii)	Ordinary Nursing	
viii)	Special Nursing, i.e., (Nurses specially engaged for the patient (state whether they are employed on the advice of the Medical Officer-in-charge- of the case at the hospital or at the request of the Railway servant or patient. In the3 former case a certificate from the Medical Officer-in-charge of the case and countersigned by the Medical Superintendent of the hospital should be attached)	
ix	Ambulance charges (State the journey to & fro from undertaken)	
x	Any other charges e.g. charges for electric light, fan, heater, air conditioning etc. (State also whether the facilities referred to are a part of the facilities normally provided to all patients and no choice was left to the patient)	

NOTE: 1. If the treatment was received by the Railway servant at his residence under Rule 7 of the Secretary of State's service (Railway services, class. I medical attendance) Rules 1941 or rule 97 of the Medical Attendance and treatment rules, give particulars of such treatment and attach a certificate from the authorized medical attendance as required by these rules

2.If the treatment was received at a hospital other than a Government Hospital, necessary details and the certificate of the authorized Medical Attendant that the requisite treatment was not available in any nearest Railway or Government hospital should be furnished.

III .CONSULTATION WITH SPECIALIST

Fee paid to a specialist or a Medical Officer other than the authorized Medical attendant, indicating:

a	The name and designation of the specialist or Medical Officer consulted and the Hospital to which attached	
b	Number and dates of consultations and the fee charged for each consultation	
C	Whether consultation was had at the hospital, at the consulting room of the specialist or Medical Officer, or at the residence of the patient.	
d	Whether the Specialist or Medical Officer was consulted on the advice of the authorized medical attendant and the prior approval of the Chief Medical Officer of the Railway servant was obtained so, a certificate to that effect should be attached.	
9	Total amount claimed	
10	List of enclosures	

DECLARATION TO BE SIGNED BY THE RAILWAY SERVANT

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 up on me.

Date:.....

Signature.....
Designation / Office

Forwarded to CMD/MAS together with the enclosures for arranging reimbursement, as admissible Payment should be made to the employee in cash in the presence of
..... / or by cheque on the bank of

No.....

Head of Department/Divisional Officer.

Date.....

Transmitted to R.A.O.....sanction is accorded to the refund of a sum of Rs.....(Rupees.....)

Vide column.....chargeable to -

Rs.....to.....Rs.....to.....

Rs.....to.....Rs.....to.....

A pay order for the amount drawn in favour of the employee is enclosed to enable him to arrange payment.

Encl:

Chief Medical Officer

No.....

Date

Note

- i) This application form shall be submitted in duplicate to CMO.
- ii) All original receipts for the expenses incurred vide column 8 should be submitted along with the application if the details of charges (daily rate, period of stay etc.) have not been furnished in the receipts, a separate certificate showing the allocation the charges should be submitted to facilitate verification of the amount claimed.
- iii) The requisition issued by the Authorized Medical Attendance should be attached if the treatment was received at a hospital other than the Govt. Hospital specified in the annexure to Rule 919 R, without which the application will not be considered.
- iv) Essentiality certificate in respect of special medicines purchased including those supplied by the Govt. Hospitals should be submitted in the prescribed form.
- v) If the treatment was availed of at a station other than H. Qrs. of the employee, the reason therefore should be explained to enable CMD to consider the application.
- vi) Reimbursement of charges incurred in Non Railway Hospital by Cl. IV Employees and their family members are not admissible.
- vii) Workshop staff on scale of pay the maximum of which is Rs 60 and below will be treated in the same was as Cl. IV staff for the purpose of Reimbursement Of Medical charges under the Rules.

C-8 SRC/R903/G268(OLD)

SOUTHERN RAILWAY

Certificate granted to Shri. / Smt.
 Wife/Daughter/Son of Shri / Smt employed the
 office of.....

CERTIFICATE-A

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

I, Dr..... hereby certify

a) that the injections administered were /were not for immunization or prophylactic purposes

b) that the patient has been under treatment at..... Hospital and that the under-mentioned medicines prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient. The medicines are not stocked in theHospital (name of Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic values are available for preparations which are primarily foods, toilets of disinfectants.

SL NO	Name of medicines	Price Rs.
1		
2		
3		
4		
5		

c) that the patient is/was suffering from..... and is/was under my treatment from.....to.....

d) that the patient is/was not given pre-promotional or post-natal treatment.

e) that the X-ray, Laboratory tests, etc., for which an expenditure of Rs.....was incurred were necessary and were undertaken on my advice at.....(Name of Hospital or Laboratory)

f) that I referred the patient to Dr..... for specialist consultation and that the necessary approval of the..... (name of the Dist. Medical Officer), as required under the rules was obtained.

g) that the patient did not require/require hospitalisation.

**Signature & Designation of the Medical
 Officer & the Hospital/Dispensary
 To which attached**

NOTE: Certificate not applicable should be struck off. Certificate © is compulsor and must be filled by the Medical Officer in all cases.

Certificate grated to Mrs/Mr/Miss.....

Wife/Son/Daughter of Mr.....

employed in the

CERTIFICATE-B

(To be completed in the case of patients who are admitted to Hospital for treatment)

PART A

(To be signed by the Medical Officer-in-charge of the case in the Hospital)

I, Dr. hereby
certify

- a) that the patient was admitted to Hospital on the advice of/on my advise
..... (Name of Medical Officer)
- b) that the patient has been under treatment at and that the under-
mentioned Medicines prescribed by me in this connection were essential for the
recovery/prevention of serious deterioration in the condition of the patient. The medicines are not
stocked in the (Name of the Hospital) for supply
to private patients and do not include proprietary preparations for which cheaper substances of
equal therapeutic values are available for preparations which are primarily foods, toilets of
disinfectants.

SL No	Name of Medicines	Price Rs.
1		
2		
3		
4		
5		

- c) that the injections administered were/were not for immunizing or prophylactic purposes
- d) that the patient is/was suffering from and is/was
under my treatment from to
- e) that the X-Ray, Laboratory test, etc., for which on expenditure of Rs. was incurred
were necessary and were undertaken on my advice at (Name of
Hospital or Laboratory)
- f) that I called in Dr. for specialist
consultation & that the necessary approval of the (Name of
District Medical Officer) as required under the rules were obtained).

**Signature of the Medical Officer-In-Charge
of the case at the Hospital**

Note: This does not apply in case under Rule 903(b) (1) R.I

PART B

I certify that the patient has been under treatment at the hospital
and that the service of 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.

Counter signed

Chief or the Principal or the District Medical Officer	Signature of the Medical Officer in charge of the case at the Hospital
---	---

Certify that the patient has been under treatment at the
Hospital and that the facilities provided were the minimum which were essential for the patient's
treatment.

Place:

Date:

Medical Superintendent

.....Hospital

NOTE: Certificates not applicable should be struck off. Certificate (d) is
Compulsory and must be filled by the Medical Officer in all cases.

PROFORMA FOR SUBMISSION OF CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY RAILWAY EMPLOYEES FOR AN AMOUNT IN PRIVATE HOSPITAL/NON RECOGNISED INSTITUTIONS

1. Name of Patient :
2. Age :
3. Name of employee
4. Designation and Office
5. Pay
6. Relationship to the employee
7. Name of Institution where treatment was taken
8. Date of Admission
9. Date of Discharge
10. Date of submission of claim
11. Reason for delay , if delayed for more than 3 months
12. Type of medical emergency
13. Was there no Railway/Govt. Facility to deal it
14. Distance of the nearest Govt. Hospital and whether
Facilities available there
15. Distance of Nearest Railway Hospital and whether
Facilities available there. If not how far is the Railway
Hospital with the facilities available
16. Distance of the Private hospital from residence/place of
Illness where facilities available

17. When was the Railway medical officer was informed

Of such admission

18. Did the patient take any treatment before or after for

The present sickness (if this existed before and if yes, when)

19. Total amount claimed (with breakup of charges)

20. Itemwise break of expenditure had the treatment in a

Government hospital

21. Verbatim views of CPO

REIMBURSEMENT CLAIM FORM

1. Name of the Railway/ Retd. employee (in BLOCK letters)
2. Designation of the Railway/ Retd. employee (in BLOCK letters)
3. Office and Station of employment
4. Pay/Last Pay of the Railway/ Retd. employee including grade pay
5. Residential address
6. MIC/ RELHS no. and issuing Authority
7. MIC/ RELHS registered at H Unit/ Hospital

- II (A) Name and age of the patient
- II (B) Patient's relationship to the Rly/ Retd. employee

III Details of Indoor Treatment at Non Railway Institute

- A. Name of Hospital:
- B. Date of Admission:
- C. Date of Discharge:
- D. Diagnosis:
- E. Amount of Total Hospital Bill (Attach detailed bill):
- F. Whether Treatment was taken in Emergency:
- G. Are you a CTSE member (Y/N):

- IV. Whether subscribing to any Health Insurance Policy¹ or covered under any other health scheme:
If yes, have you received any amount from insurance company for the treatment in question. Give details if any on separate sheet of paper.

V. Total Amount Claimed:

VI. Details of Bank account where Reimbursement amount is to be paid:

- | | |
|---------------------|----------------|
| a. Name of Bank | b. Account No. |
| c. Branch MICR Code | d. IFSC Code |

VII. List of enclosures (Please Tick the documents attached and write additional documents)

- A. Photocopy of MIC/ RELHS card
 - B. Essentiality cum Emergency Certificate by the Non Rly Hospital
 - C. Discharge Summary
 - D. Original Bills of Hospital
 - E. Original Cash vouchers of Drugs/consumables/implants etc. if relevant
 - F. Outer pouch of Stent, pacemaker, Implants etc.
 - G. Any other enclosure
- (In case of many enclosures, write number of additional enclosures here and attach a separate sheet with details)

DECLARATION TO BE SIGNED BY THE RAILWAY EMPLOYEE

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. I am aware that misuse of medical facilities or misrepresentation of any kind can attract penal action including cancellation of MIC/ RELHS Card. I hereby declare that this is my final claim and I shall not make any claim in future to Rly or any other health scheme in respect to this treatment episode.

Date.....
Place

.....
Signature of the Railway employee.

¹ In case the beneficiary has medical insurance policy and intend to make claim for the treatment in question then he/she may make claim to insurance company first and then submit claim to Rly with documents, bills etc. attested by insurance company.

..... RAILWAY
MEDICAL DEPARTMENT

ESSENTIALITY ~~and~~ EMERGENCY CERTIFICATE

I certify that Shri/Shrimati/Kumar/Kumari wife / son /
daughter / dependent relative of Shri / Shrimati
employed in Indian Railway as , has been under my treatment for
..... disease from to
at the hospital and that the treatment as described in the attached
Discharge Card No. and attached bills thereon were provided due to an emergency
situation, treatment for which could not have been delayed. I further certify that the treatment provided was
essentially required.

.....
Signature of the Medical Officer
In charge of the case at the non-Railway hospital.
with Name and Stamp/Seal

Signature of Hospital In-charge or
Authorized signatory with Stamp/Seal