CHECK LIST IN CONNECTION WITH MEDICAL RE-IMBURSEMENT BILL

Medical Re-imbursement bill in respect of:

Treatment Done at

Sl. No.	*List of Particulars / Documents / Papers*	*Mark whether Yes/No*	
1	Admissable Report from Jt. DHS., _ _ _ _ _ _ _ _ _ _	YES / NO	
2	Check list/Minutes/Approval of the District Level Admissiblity Board	YES / NO	
3	Approval of Director of Health Service Assam	YES / NO	
4	Physical Verification Report /Genuineness of D.D.O.	YES / NO	
5	Death / Birth Certificate	YES / NO	
6	Next of Kin Certificate	YES / NO	
7	Pension Payment Order / DCRG	YES / NO	
8	Attested copy of Bank Pass Book	YES / NO	
9	Attested copy of G.P.F. / P.F. Statement	YES / NO	
10	Leave order	YES / NO	
11	Self declaration of no claim from other source	YES / NO	
12	Referral Medical Board’s Certificate	YES / NO	
13	Certificate of Hospital	YES / NO	
14	Discharge/Death Summary	YES / NO	
15	Records of Hospital	YES / NO	
16	Essentiality Certificate	YES / NO	
17	Final bill/bill summary	YES / NO	
18	Bills/vouchers etc (in original)	YES / NO	
19	Other information/papers	YES / NO	
20	A.M.A. Recommendation	YES / NO	

DECLARATION

Date –

I, Sri/Smt. _ Retired/ _ of _ under _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ district, do hereby state that I have done my _ treatment at _ from _ _ _ _ _ _ _ _ _ _ to _ _ _ _ _ _ _ _ _ _ .

I, do hereby declared that I have not claim ***or*** not drawn the aforesaid Medical Re-imbursement bill from any other Govt. source.

Signature of the claimant

ESSENTIALITY CERTIFICATE

Certified that _ employee of the _ District _ _ _ _ _ _ _ _ _ _ _ _ has been under my treatment for _ with effect from _ _ _ _ _ _ _ _ _ to _ _ _ _ _ _ _ _ at _ and that the under mentioned medicine /test prescribed by me are essential for recovery / preventio0n of serious deterioration in the condition of the patient. The medicines are not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparations which are primarily food, toilets of disinfectants

Sl. No.	***Name of Medicines***	***Voucher No. & Date***	***Quantity***	***Amount***

Total:

Signature of the Authority
Medical Attendant with Designation & Seal

OFFICE

Memo No. Date:

TO WHOME IT MAY CONCERN

It pleases me to certify that Sri/ Smt./ Md./Late _ was suffering from _ _ _ _ _ _ _ _ _ _ __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ problems and done her treatment at _ Hospital, _ _ _ _ _ _ _ _ _ _ from _ _ _ _ _ _ _ _ _ _ to _ _ _ _ _ _ _ as referred by the _ _ _ _ _ _ _ _ _ _ _ Medical College & Hospital, _ _ _ _ _ _ _ _ _ .

It is also certified that the Medical Re-imbursement claim preferred by Sri/ Smt./ Md./Late _ in connection with medical treatment as stated above, is found to be genuine.

(_ _ _ _ _ _ _ _ _ _ _)
D.D.O. / Inspector of Schools,
_ _ _ _ _ _ _ _ _ _ _ _ _