

ANNEXURE - C

MEDICAL REIMBURSEMENT CLAIM FORM FOR OUTDOOR TREATMENT

1. Name of Employee: _____ 2. Designation: _____
3. Reg. No.: _____
4. Salary (Basic Pay + DA)/Pension (as on 01-04-----): _____
5. Place of Duty: _____ 6. Name of Patient: _____
7. Relationship with Employee: _____ 8. Age: _____
9. Reimbursement claimed under:
(Tick relevant box)
• Treatment from RMP (as per Para 2.1.0)
• Treatment from P&T Dispensary (as per Para 2.1.2)
10. Nature of illness: _____
11. Name of Doctor/Hospital: _____
12. Details of claim:
(attach prescription, vouchers, etc. in duplicate)

	Voucher No.
	Amount
• Consultation:	
• Diagnostics/Tests:	
• Medicines:	
• Appliances:	
• Special treatment (e.g. Physiotherapy, Yoga etc.):	
• Others:	

	Total:
	(Rupees-----)

Declaration:
I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is wholly dependent on me.

(Signature of Employee)

ANNEXURE – D

**MEDICAL REIMBURSEMENT CLAIM FORM FOR INDOOR
TREATMENT**

1. Name of Employee:
2. Designation:
3. Reg. No.:
4. Salary (Basic Pay + DA)/Pension (as on 01-04-----):
5. Place of Duty:
6. Name of Patient:
7. Relationship with Employee:
8. Age:
9. Nature of illness:
10. Name of Doctor/Hospital:
11. Period of treatment: From ----- To-----
(Certificate issued by the Medical Officer in-charge of the hospital as per enclosed proforma is to be attached)
12. Details of claim:
(attach prescription, vouchers, etc. in duplicate)

	Voucher No.	Amount
• Consultation:		
• Diagnostics/Tests:		
• Medicines/Injections:		
• Appliances:		
• Room Rent:		
• Charges for Nurses:		
• Others:		
	Total: _____	
	(Rupees-----)	

Declaration:

I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is fully dependent on me.

(Signature of Employee)

CERTIFICATE FOR HOSPITALIZATION

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

Certificate granted to Mrs./Mr./Miss _____, husband /wife /son /daughter /mother /father of Mrs/Mr _____ employed in the office of _____,BSNL.

PART 'A'

I, Dr. _____ hereby certify:

- (a) that the patient was admitted to hospital on _____.
- (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.
- (c) that the patient is/was suffering from _____ and is/was under treatment from _____ to _____.
- (d) 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);

Signature and Designation of the
Medical Officer In-charge of the
case at the hospital

BHARAT SANCHAR NIGAM LTD.

APPLICATION FORM FOR MEDICAL ADVANCE

For Working Employees

1. Name of Patient
2. Relationship with Employee:
3. Age:
4. Name of Disease (for which hospitalization is required):
5. Name of Hospital:
6. Name of Employee:
7. Designation:
8. Salary (Basic + DA)/Pension:
9. Basic Pay:
10. Estimated cost of treatment
(Enclose original copy of hospital's estimate)
11. Amount of Advance required for treatment:

Signature:
Designation:
Section:
Tel. No.:

ANNEXURE - F



Bharat Sanchar Nigam Ltd.
(A Govt. of India Enterprise)

No.

Date:

**AUTHORISATION LETTER FOR TREATMENT IN
HOSPITAL**

This is to certify that Sh./Smt.----- (Name of the patient), Age----- is the Husband/Wife/Son/Daughter/Mother/Father of Sh./Smt.-----, an employee of BSNL. He/She may be admitted in (Hospital's Name) ----- as per his/her room entitlement, i.e. -----.

He/She may be charged as per agreed rates with BSNL.
Bills as per agreed rates may be sent to this office for payment.

(Signature of the Competent Authority)