Accounts
24/8/22

No. F.1(1)/FIN(B)/2022-23/L-I/23933-24063
GOVERNMENT OF TRIPURA
FINANCE DEPARTMENT
(BUDGET BRANCH)
*****

Dated, Agartala, the 20th August, 2022.

**MEMORANDUM**

The existing Form for Medical Reimbursement Claim is little cumbersome. The Format adopted by Central Government is comparatively simple. The matter has been examined in the Finance Department and it has been decided to adopt the same for the purpose of Medical Reimbursement Claim for employees under State Government. A copy of the Form is enclosed herewith for ready reference.

All the Administrative Departments are requested to follow the Form for the purpose of Medical Reimbursement Claim. This will come into force with immediate effect.

This is issued with approval of the competent authority communicated vide U.O. No. 1087/Dy.CM/FIN/2022-23 dated 13.08.2022.

**(A. Sarkar)**
Additional Secretary
Finance Department
Government of Tripura.

Enclo: Form for Medical
Reimbursement Claim.

To,

1. All Principal Secretaries/ Secretaries/ Special Secretaries.
2. The PCCF.
3. The DGP.
4. All Heads of Departments.
5. The AG (A&E)/ AG (Audit), Tripura, Agartala.
6. All Treasury/ Sub-Treasury Officers.

Copy to:

1. PS/PA to the Hon'ble Deputy Chief Minister, Government of Tripura for kind information.
2. PS/PA to the Chief Secretary, Government of Tripura for kind information.

Copy also to:

1. The Manager, Tripura Government Press with a request to print sufficient copies of the Application Form, which may be procured by different administrative departments.

GOVERNMENT OF TRIPURA
DIRECTORATE OF SECONDARY EDUCTAION
(ACCOUNTS SECTION)
SHIKSHA BHAWAN,AGARTALA,TRIPURA

No.F.7(2)-SE/ACCTS/2022/873 Dated, Agartala, the 29th August,2022

Copy Forwarded to:

1. The District Education Officer, West/South/Gomati/Sepahijala/ North/Dhalai/Unakoti/Khowai for further circulation to the Head of Offices & DDO's under their jurisdiction.
2. The Branch officer, Grant-In-Aid Section, DSE for information and circulation to the G.I.A Schools.
3. The Head of Office & DDO (Estt. HQ), DSE for information and necessary action.
4. The Web Administrator, DSE for uploading this Memorandum in the web-portal of this Directorate.

Yours faithfully,

**(P.K Mallik)**
**Officer on Special Duty,**
Branch Officer, Accounts Section
Directorate of Secondary Education
Tripura

Enclo: -As Stated above.

# APPLICATION FOR MEDICAL REIMBURSEMENT CLAIM

| | | |
|---|---|---|
| 1. | Name and designation of Govt. Servant (In Block Letters) | : |
| 2. | Whether married or unmarried, if married the place where wife/ husband is employed | : |
| 3. | Office in which employed | : |
| 4. | Pay and allowances of the Govt. Servant | : |
| 5. | Place of duty | : |
| 6. | Actual Residential Address | : |
| 7. | Name of patient and his/ her relationship | : |
| 8. | Place at which the patient feel ill | : |
| 9. | Nature of illness & duration | : |
| 10. | Name & designation of the Doctor | : |
| 11. | Total amount claimed | : |
| 12 | List of Enclosure(s) | : |

## Declaration to be signed by the Govt. Servant

I do hereby declare that the statements in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred in wholly dependent upon me.

Place:
Date:

Signature of the Govt. Servant
Section to which attached.....

# ESSENTIALITY CERTIFICATE

## CERTIFICATE 'A'

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

Certificate granted to Mrs./Mr./Miss _____

wife/son/doughter of Mr. _____ employed

in the _____

I, Dr. _____ hereby certify

(a) that I charged and received Rs. _____ for _____

consultation on _____ (dates to be given) at my consulting room/

at the residence of the patient.

(b) that I charged and received Rs. _____

for administering _____ intra-venous/intra-muscular/subcutaneous

injections on _____ (dates to be given) at _____

my consulting room/the residence of the patient.

(c) that the injections administered were not/were for immunising or prohy lactic purposes;

(d) that the patient has been under treatment at _____ hospital

my consulting room and that the undermentioned medicines prescribed by me in this connection were essential for the recovery / preventioned of serious deteriortion the condition of the patient.

The medicines are not stocked in the _____

(name of hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets ro disinfectants.

| *Name of medicines* | *prices* |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |
| 7. _____ | _____ |
| 8. _____ | _____ |
| 9. _____ | _____ |
| 10. _____ | _____ |

Contd. P/2

(a) that the patient is/was suffering from _____ and is/was under my treatment from _____ to _____

(f) that the patient is/was not given pre-natal or post natal treatment :

(g) that the X-ray, laboratory test, etc. for which an expenditure of Rs. _____ was incurred was necessary and were undertaken on my advice at _____ _____ (name of the hospital or laboratory);

(h) that I referred the patient to Dr. _____ for specialist consultation and that the necessary approval of the _____ _____ (name of the Chief Administrative Officer of the State) as required under the rules was obtained.

(i) that the patient did not require/required hospitalisantion.

Dated _____

*Signature of AMA/Designation of the Medical Officer and hospital/ dispensary to which attached*

**N.B. :-** Certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by Medical Officer in all cases.

## ESSENTIALITY CERTIFICATE

## CERTIFICATE 'B'

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

Certificate granted to Mr./ Mrs./ Miss .....

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

Employed in the .....

### PART-A

I, Dr. ..... hereby certify

(a) that the patient was admitted to hospital on the advice of ..... ..... .....(Name of Medical Officer)/ on my advice:

(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 value are available nor preparation which are primarily foods, toilets or disinfectants:

| | Name of medicines | Price |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

(c) that the injections administered were not for immunizing or prophylactic purposes:

(d) that the patient is/ was suffering from ..... ..... ..... and is /was under treatment from ..... ..... to .....

(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 called on Dr ..... ..... ..... ..... ..... for Specialist consultations and that the necessary approval of the ..... (name of the Chief Administrative Medical Officer of the state) as required the rules, was obtained.

.....

Signature and Designation of the Medical Officer Incharge of the case at the Hospital.

**PART 'B'**

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

.....

Signature of the Medical Officer
Incharge of the case at the Hospital

**COUNTERSIGNATURE**

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

Medical Superintendent
.....Hospital

Place:

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