KERALA STATE ROAD TRANSPORT CORPORATION

FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES OF KSRTC EMPLOYEES AND THEIR FAMILIES

1. Name (In Block letters) & Designation of employee with PF. No. :

2. Pay & scale of Pay :

3. Office in which employed :

4. Place of duty :

5. Residential Address :

6. (i) Name of patient and relationship of the employee to the patient :

   (ii) If the patient is spouse of the Employee, state whether he/she is Employed, with details (If employed, a declaration of non-receipt of the claim in any form is to be attached) :

7. Place where the patient fell ill :

Hospital Treatment

8. Whether hospitalized or not :

9. If hospitalized whether in Govt: hospital or private (notified) hospital and name of hospital :

10 If hospitalized outside the State
   1. Whether the patient was on duty :
   2. Name of Institution :

11. If on special treatment outside the state
   1. Name of Institution :
   2. Whether Certificate of Director of Health Service as contemplated in Rule 7(a) is attached. :
   3. Whether prior sanction of Director Of Health Service has been obtained :

12. Last date of treatment :

Charges

13. Details of amount claimed (List of medicines Cash memo, and essentiality certificate Should be attached separately) :

(a) (i) Treatment in Govt: Hospital (Medicines) :Rs.

(ii) Treatment in private Institution (Bills to be certified indicating Emergency of the case) :Rs.

(b) 1. Charges for medicine :Rs.

2. Charges for treatment :Rs.

3. Charges for accommodation :Rs.

4. Charges for Lab.services etc. :Rs.

5. Charges for Diet :Rs.

14. Total amount claimed (in figures & words) :

15. List of enclosures

1.	Essentiality Certificate	: *Enclosed/Not enclosed
2.	List of Cash Bills	: *Enclosed/Not enclosed
3.	Certificate of Medical Officers	: *Enclosed/Not enclosed
4.	Certificate and declaration	: *Enclosed/Not enclosed

16. Declaration to be signed by the employee

I, hereby declare that the statements given above are true to the best of my knowledge and belief and the person for whom medical expenditure has been incurred is wholly dependant on me.

Signature of the employee

Place: Name:

Date: Designation:

Unit:

17. Declatation

a) I. . . . . (Name) employed in the . . . .(Name of Unit) hereby declare that I/my wife/son/daughter/mother/father have /has/had been under treatment at. . . . .(Name and place of hospital) during the period from. . . . . to. . . . . .and I/he/she have/has received the benefits of one system of treatment only and not taken advantage of ore than one system simultaneously.

(b) I, also declare that my wife/husband/son/daughter/dependant parent who is the patient is not employed anywhere and not in receipt of any remuneration.

Station:
Date:

Signature:

Name of employee:

Designation:

18. **Certificate of the Unit Officer**

1. Certified that the claim of Shri./Smt. . . . . ……. .. . .
. . .. … . . . . was received in this office on. . . . . and the pay and scale of pay noted in his application are correct.

Station:
Date:

Signature of Unit Officer.

2. [To be certified by the Unit Officer when the claim is resubmitted after rectifying defects pointed out from C.O.]

Certified that he claim of Sri/Smt. . . . . was received in this Office on. . . . . .after rectifying the defects pointed out from Chief Office.

Station:
Date:

Signature of Unit Officer.

Tick mark the necessary entry

CHECK LIST FOR SANCTIONING OF REIMBURSMENT OF MEDICAL EXPENSES

[Each item should be tick marked in token of verifications,* EC-Essentiality Certificate]

Name of Applicant……………………………………………Designation……………….

Unit………………………..Name of Patient……………………………………………

Relationship…………………………..

CHECK THE FOLLOWING ITEMS IN THE APPLICATION

No.	Sl.No.	Item	Yes/No
1.	Sl.No. 1 to 5	Whether correct as per service records	Yes/No
2.	Sl.No. 6 to 7	Whether the information is complete and declaration required is furnished	Yes/No/NA
3.	Sl.No. 8	Whether attested copy of OP ticket/ discharge certificate in the case of out-patient/ in-patient respectively is enclosed	Yes/No
4.	Sl.No. 9	Whether certificate from Authorized Medical Attendant counter signed by the concerned DMO is furnished in the case of treatment in notified private hospital	Yes/No/NA
5.	Sl.No.10 & 11	Whether the information are complete & certificate from DHS produced	Yes/No/NA
6.	Sl.No.12	Whether the date of submission of claim is within 30 days from the date of last treatment and cash bills for more than 30 days enclosed if on continuous treatment or whether the the last date of treatment if not on continuous treatment	Yes/No
7.	Sl.No.13 &14	Whether all cash bills as per EC are enclosed and the amount under each item tallies with total amount claimed	Yes/No
8.	Sl.No.15	Whether the enclosures are furnished as per list	Yes/No
9.	Sl.No.16, 17 (a) & 17(b)	Whether the declarations are properly filled and signed	Yes/No
10.	Sl. No.18(1)	Whether the date of submission of the claim is correct furnished	Yes/No
11.	Slo.No. 18(2)	Whether the correct date of re-submission is noted	Yes/No/NA

OTHER DETAILS

12. Whether the name of patient, period of treatment and name of disease are filled in the EC — Yes/No

13. Whether the cash bills are recorded date-wise and relevant details relating to each bill are recorded in the EC — Yes/No

14. Whether the total amount claimed in EC tally with the total amount as per cash bills attached — Yes/No

15. Whether EC is signed by the Authorized Medical Attendant under his name and seal and Office Seal of Hospital is affixed — Yes/No

16. Whether all the cash bills of medicines bear the certificate "administered to the patient" by the Medical Officer under his name and seal — Yes/No

CERTIFICATE

Certified that every entry in this application has been checked with the check list and found correct

Rs……………………(Rs………………………………………………………..only) may be sanctioned.

Also certified that the following amounts have been paid to him in the entire service till date

1. Medical Allowance Rs……………………
2. Medical Re-imbursement Rs……………………..
3. Medical Advance (Financial Assistance) Rs……………………….

Signature Name of Asst/Estt.Sn	Signature Name of Supdt/Estt.Sn

Verified in audit and found admissible for Rs……………(Rs………………..

……………………………………………..only)

Also certified that the amount paid till date as noted above is correct

Signature Name of Asst/Audit	Signature Name of Supdt/Audit	Signature Admn, Officer	Signature Unit Officer.