M/15/438

Office of Senior Medical Officer
Receipt No. 192
Dated 2/2/2020

From

The Comptroller,
CCS HAU, Hisar.

To

All the Deans/Directors/HODs/Offices/Sections,
(including outstations),
CCS HAU, Hisar.

Memo No. CAUH/E.1/144/2020/ 25961-26080
Dated: 31/01/2020

Sub: Reimbursement of Medical Claims- revision/updation of forms.

Please refer to this office letter no. CAUH/E.1/2007/ 10842-992 dated 13.9.2007, vide which a copy of prescribed performae were circulated to all the departments for claiming medical reimbursement to the University employees/ retirees/pensioners & their dependants.

2. Now, as per orders of the worthy Vice-Chancellor; to facilitate the claimant in submission of medical claims, the performae for claiming reimbursement of medical expenses have been translated in Hindi language, wherever necessary. Further, a checklist for reimbursement of medical claims to be fulfilled by the claimant has also been approved by the competent authority. A copy of updated/translated form for reimbursement of medical expenses, form AU 5/10, Essentiality certificate & checklist is enclosed.

3 You are, therefore, requested to ensure that all the medical reimbursement bills are prepared by the claimants, so entitled, relating to your office/Deptt. on the proformae prescribed. The contents of this letter may be got noted from all concerned for strict compliance. This is in continuation of this office letter no. 20141-20260 dated 27.11.2019.

Encls : As above.

Comptroller 31/1/20

CC :

1. The SPS to Vice-Chancellor, CCSHAU, Hisar.
2. The Registrar, CCS HAU Hisar w.r.t. his endst. no. Admn.E-2/2019/S-108/37300-09 dated 19.11.2019.
3. The DSW, CCS HAU Hisar.
4. The SMO, Campus Hospital, CCS HAU Hisar.
5. The Joint Director (Local Audit), CCSHAU, Hisar.
6. The Incharge, Technical Cell, COBS&H, CCSHAU, Hisar for uploading the aforesaid instructions on the University website.
7. All Dy. Registrars/ ARs/ A&AOs/ Supdts./ E-2/ E-3 & E-4 (Internal) and P.S. to CAU.
8. The Presidents, HAUTA/HAUNTEA, CCS HAU, Hisar.
9. The President, Senior Citizen (Retd.) Welfare Council, Hisar.

Check List For Chronic Disease Patients.

1. Original claimed bills duly attested by the claimant and written as ' attested and paid by me'
2. Original investigation/lab test reports.
3. Original OPD prescription slip with stamp of treating doctor
4. Photocopy of chronic disease certificate.
5. Essentiality certificate should be completely filled mentioned with last basic pay details and should be signed by the treating doctor and medical superintendent.
6. Form AU 5/10 attached with photo of the patient which should be attested by the HOD/ Competent Authority of the respective department.
7. Contact No. of the claimant.
8. Signature of the treating doctor on discharge summary and not the proprietor/owner of the hospital.
9. For those private hospitals where Medical Superintendent is not available two separate stamps will be required **one for MS and other for Treating Doctor.**

Check List For Indoor Patients.

1. Original claimed bills duly attested by the claimant and written as ' attested and paid by me'. These bills should also be verified by the treating hospital.
2. Original investigation/lab test reports.
3. Original discharge summary duly stamped and signed by the treating doctor.
4. Essentiality certificate should be completely filled up and stamped and signed by the treating doctor and medical superintendent, also mentioned the last basic pay.
5. Form (AU 5/10) should be duly attested by the HOD/Competent authority of the respective department alongwith an attested photo of the patient.
6. Copy of health card in case of dependants bills.
7. Contact No. of the claimant.
8. Signature of the treating doctor on discharge summary and not the proprietor/owner of the hospital.
9. For those private hospitals where Medical Superintendent is not available two separate stamps will be required one for MS and other for treating doctor.

Form AU 5/10
(Referred to in Rule 5.14(1))

CCS HARYANA AGRICULTURAL UNIVERSITY, HISAR
Form for Reimbursement of Medical charges

Name & Designation of the employee claiming re-imbursement, with Department:

Sr.No.	Name & relationship of the patient with the University employee	Disease as diagnosed by the authorized Medical Officer	Name of medicine on a/c of which the expenditure was incurred	Amount of the bill (Rs.)	Place of posting	Reasons for incurring expenditure at place other than the place of duty/posting	Period of treatment	Remarks
1	2	3	4	5	6	7	8	9
	Name of patient…… Relationship with the Univ. employee….. Photograph of the patient…….. above particulars attested HOD/Officer countersigned CMO							

Certified that

i) Parents, as mentioned above, are wholly dependent upon me and have no other source of Income.

ii) They reside with me at the place of my duty;

iii) The medicines purchased have been fully used;

iv) In case spouse is working:

a) Certified that my wife/husband is not getting any fixed medical allowance from any source.

b) certified that my wife/husband is employed and is not getting medical reimbursement from any other source. An affidavit to this effect has already been furnished.

Signature of the employee
(with date)

Counter signature.....
Designation.....

Certified that the medicines as detailed herein are not available in the Campus Dispensary and are admissible under the Govt. Medical Attendance Rules.

Medical officer
CCS HAU

Note: 1. Prescription should indicate:
a) Name of the Medicine in legible handwriting.
b) Quantity of the medicine to be purchased from the market.
2. Cash Memo/Vouchers should be duly verified and attested by the employee concerned in token of payment having been made.
3. Name of the medicine to be given in capital letters on the reverse side of the voucher.
4. Sanction of the competent authority to be enclosed.

Form AU 5/10
(Referred to in Rule 5.14(1))

चौधरी चरण सिंह हरियाणा कृषि विश्वविद्यालय, हिसार

चिकित्सा शुल्क की प्रतिपूर्ति के लिए प्रपत्र

प्रतिपूर्ति का दावा करने वाले कर्मचारी का नाम, पदनाम तथा विभाग .....

क्र.सं.	रोगी का नाम और विश्वविद्यालय के कर्मचारी के साथ संबंध	बीमारी का नाम जिसको अधिकृत चिकित्सा अधिकारी द्वारा जांचा/निदान किया गया	दवा का नाम जिस पर खर्च किया गया (अंग्रेजी भाषा व बड़े अक्षरों में)	बिल की राशि (रूपये)	नौकरी का स्थान	नौकरी के स्थान के अलावा किसी अन्य स्थान पर खर्च के कारण	उपचार की अवधि	टिप्पणी
1	2	3	4	5	6	7	8	9
i) ii) iii)	रोगी का नामः विश्वविद्यालय कर्मचारी के साथ संबंध रोगी की फोटो above particulars attested HOD/Officer countersigned CMO							

प्रमाणित है किः

1. माता, पिता जैसा कि ऊपर उल्लेख किया गया है, पूर्ण रूप से मुझ पर आश्रित हैं और उनकी आय का कोई अन्य स्त्रोत नहीं है।
2. वे मेरी नौकरी के स्थान पर मेरे साथ रहते हैं।
3. खरीदी गई दवाइयों का पूरी तरह से उपयोग किया गया है।
4. मामले में यदि पति/पत्नी काम कर रहे हैं
   (क) प्रमाणित किया जाता है कि मेरी पत्नी/पति को किसी भी स्त्रोत से कोई निशिचित चिकित्सा भता नहीं मिल रहा है।
   (ख) प्रमाणित किया जाता है कि मेरी पत्नी/पति कार्यरत हैं और उन्हें किसी अन्य स्त्रोत से चिकित्सा प्रतिपूर्ति नहीं मिल रही है। इस आशय का एक शपथपत्र पहले ही दिया जा चुका है।

कर्मचारी के हस्ताक्षर
(दिनांक के साथ)

Countersignature.....
Designation.....

Certified that the medicines as detailed herein are not available in the Campus Dispensary and are admissible under the Govt. Medical Attendance Rules.

Medical officer
CCS HAU

Note:
1. Prescription should indicate:
   a) Name of the Medicine in legible handwriting.
   b) Quantity of the medicine to be purchased from the market.
2. Cash Memo/Vouchers should be duly verified and attested by the employee concerned in token of payment having been made.
3. Name of the medicine to be given in capital letters on the reverse side of the voucher.
4. Sanction of the competent authority to be enclosed.

CCS HARYANA AGRICULTURAL UNIVERSITY, HISAR
ESSENTIALITY CERTIFICATE
(To be filled in Capital Letters)

Name of Claimant_____Designation_____Period of Treatment From_____To _____ Department_____
Indoor No._____Date_____Pay_____Outdoor No._____Date_____
Proof of Identity (Aadhar Card/University ID Card)_____

I Certify that Mr./Mrs._____ son/daughter/wife/mother/father of Mr./Mrs._____ employed in the office of the_____has been under my treatment in the _____ Hospital/Dispensary in my consultation and that the under mentioned medicines prescribed by me in this connection were absolutely essential in the condition of the patient. The medicines were not stocked in the _____(Name of Hospital/Dispensary) for the supply to the patient and do not include preparation for which cheaper substitute of equal the repute value are available/nor the preparations prescribed are primary food/toilets/ tonics or disinfectants.

1. Certified that medicines have no cheaper and effective substitute.
2. Certified that the treatment given was indoor/outdoor.
3. Certified that the price claimed is reasonable.
4. Certified that the medicines are not in the nature of tonics or food or vitamins etc., the cost of which is not reimbursable in the Govt. orders issued on this subject from time to time.
5. He/she is suffering from_____(in capital letters)

S.No.	Name & Quantity of medicines in capital letters	Outdoor ticket No. & Date on which prescribed	Date on which actually purchased	Price Rs. P.

Countersignature and designation of Medical Supdt./ SMO/Authorized Doctor of the Hospital/College

Name in capital letters_____
(with Stamp)

Checked & verified the bill

Medical Officer Pharmacist Asstt.

Countersignature

Signature and Designation of the Authorized Medical Attendant/Officer
Name (in Capital letters)_____
(with stamp)

Senior Medical Officer
Campus Hospital, CCS HAU Hisar

MEDICAL RE-IMBURSEMENT FORM

In case of Indoor Treatment:-

Certified that the medicines claimed in this bill are as per bed ticket (No. _____) relates to the case.

Signature & Stamp of the
Authorized Medical Attendant/Officer

Certified that :-

1. The Medicines have actually been purchased by me during the course of treatment.
2. I am living in the House No._____and as proof of identity, a copy of Aadhar Card/Identity card issued by the University is enclosed.
3. In case of wife/children :-

   That the patient Mr./Mrs._____ is my _____and he/she is wholly dependent upon me and is residing with me and he/she is unmarried and un-employed (in case of sons/daughters).
4. For parents only :-

   His/her total monthly income does not exceed Rs.3500/- P.M. and my mother/father is/are residing with me.
5. In case spouse is working :-
   a) Certified that my wife/husband is not getting any fixed medical allowance from any source.
   b) Certified that my wife/husband is employed and is not getting any medical re-imbursement from any other source. An affidavit to this effect has been furnished.
   c) Certified that I am not adhoc employee and am working on regular basis.

Signature of the Claimant

Name(in capital letters)

Designation.....

Place _____

Date _____

चौधरी चरण सिंह हरियाणा कृषि विश्वविद्यालय, हिसार
आवश्यकता प्रमाण–पत्र

दावेदार का नाम..... पद..... पहचान का प्रमाण (आधार कार्ड / विश्वविद्यालय पहचान पत्र).....उपचार की अवधि: .....से.....

विभाग..... इनडोर (indoor) नंबर..... दिनांक.....

वेतन..... आउटडोर (outdoor) नंबर..... दिनांक.....

I Certify that Mr./Mrs._____ son/daughter/wife/mother/father of Mr./Mrs. _____ employed in the office of the_____has been under my treatment in the _____ Hospital/Dispensary in my consultation and that the under mentioned medicines prescribed by me in this connection were absolutely essential in the condition of the patient. The medicines were not stocked in the_____(Name of Hospital/Dispensary) for the supply to the patient and do not include preparation for which cheaper substitute of equal the repute value are available/nor the preparations prescribed are primary food/toilets/ tonics or disinfectants.

1. Certified that medicines have no cheaper and effective substitute.
2. Certified that the treatment given was indoor/outdoor.
3. Certified that the price claimed is reasonable.
4. Certified that the medicines are not in the nature of tonics or food or vitamins etc., the cost of which is not reimbursable in the Govt. orders issued on this subject from time to time.
5. He/she is suffering from_____(in capital letters)

क्र.सं.	दवा का नाम और मात्रा (अंग्रेजी भाषा व बड़े अक्षरों में)	Outdoor ticket no. & और दवाइयां निर्देशित (प्रेस्कराइब्ड) करने की दिनांक	दिनांक जब वास्तव में दवाइयां खरीदी गई	कीमत

Countersignature and designation of
Medical Supdt./
SMO/Authorized Doctor of the
Hospital/College

Checked & verified the bill

Medical Officer Pharmacist Asstt.

Name in capital letters_____
(with Stamp)

Countersignature

Signature and Designation of the Authorized
Medical Attendant/Officer
Name (in Capital letters)_____
(with stamp)

Senior Medical Officer
Campus Hospital, CCS HAU Hisar

MEDICAL RE-IMBURSEMENT FORM

In case of Indoor Treatment:-

Certified that the medicines claimed in this bill are as per bed ticket (No._____) relates to the case.

Signature & Stamp of the
Authorized Medical Attendant/Officer

प्रमाणित है कि:–

1. उपचार के लिए दवाइयां वास्तव में मैनें खरीदी हैं।
2. मैं मकान नंबर..... में रह रहा हूँ और पहचान के प्रमाण के तौर पर मेरे आधार कार्ड/विश्वविद्यालय द्वारा जारी किये गए पहचान पत्र की प्रति संलग्न है।
3. पत्नी/बच्चों के मामले में:–
   कि रोगी श्री/श्रीमती .....मेरा ..... है और वह पूरी तरह से मुझ पर आश्रित है और वह मेरे साथ रह रहा/रही है और वह अविवाहित और बेरोजगार है (पुत्र/पुत्रियों के मामले में)।
4. केवल माता–पिता के लिए:–
   उनकी कुल मासिक आय रु. 3500/– से अधिक नहीं है तथा मेरे माता/पिता मेरे साथ रह रहा है/रही है/रहे हैं।
5. यदि पति या पत्नी काम कर रहे हैं:–
   (क) प्रमाणित किया जाता है कि मेरी पत्नी/पति को किसी भी स्त्रोत से कोई निश्चित चिकित्सा भत्ता नहीं मिल रहा है।
   (ख) प्रमाणित किया जाता है कि मेरी पत्नी/पति कार्यरत हैं और उन्हें किसी अन्य स्त्रोत से चिकित्सा प्रतिपूर्ति नहीं मिल रहा है।इस आशय का एक शपथपत्र पहले ही दिया जा चुका है।
   (ग) प्रमाणित किया जाता है कि मैं एडहॉक कर्मचारी नहीं हूँ और नियमित आधार पर काम कर रहा/रही हूँ।

दावेदार के हस्ताक्षर

नाम.....

पद.....

स्थान.....
तरीख.....

(इनडोर रोगियों (Indoor Patient) के लिए चेकलिस्ट।)

1. मूल दावा (original claim) किए गए बिल दावेदार (Claimant) द्वारा विधिवत रूप से सत्यापित (attested) किए गए और 'मेरे द्वारा सत्यापित और भुगतान किए गए' के रूप में लिखे गए हैं।
2. मूल जाँच (original investigation) / प्रयोगशाला परीक्षण (lab test) रिपोर्ट।
3. मूल (original) डिस्चार्ज सारांश (discharge summary) को इलाज करने वाले डॉक्टर (Treating doctor) द्वारा विधिवत मुहर (stamp) लगाई और हस्ताक्षरित (signed)किया गया।
4. आवश्यक प्रमाण पत्र (Essentialilty Certificate) को अस्पताल की मुहर लगी हुई और इलाज करने वाले डॉक्टर (Treating Doctor) और चिकित्सा अधीक्षक (Medical Supreintendent) द्वारा हस्ताक्षरित किया जाना चाहिए, जिसमें अंतिम मूल वेतन (last basic pay) का भी उल्लेख किया गया है।
5. फार्म एयू 5/12 (Form AU 5/12) मरीज की फोटो के साथ संलग्न किया जाना चाहिए जिसे संबंधित विभाग के एचओडी (HOD) / सक्षम प्राधिकारी (Competent Authority) द्वारा सत्यापित (attested) किया जाना चाहिए ।
6. आश्रितों (Dependants) के बिल के मामले में स्वास्थ्य कार्ड (health card) की प्रतिलिपि (Copy) ।
7. दावेदार (Claimant) के संपर्क नंबर और I- कार्ड की प्रति(copy)।
8. निर्वहन सारांश (Discharge Summary) पर उपचार करने वाले डॉक्टर के हस्ताक्षर ।

(पुरानी बीमारी के रोगियों (Chronic Disease Patients) के लिए जाँच सूची।)

1. मूल दावा (original claim) किए गए बिल दावेदार (claimant) द्वारा विधिवत रूप से सत्यापित (attested) किए गए और 'मेरे द्वारा सत्यापित और भुगतान किए गए' के रूप में लिखे गए हैं।
2. मूल जाँच (original investigation) / प्रयोगशाला परीक्षण (lab test) रिपोर्ट।
3. इलाज कर रहे डॉक्टर की मोहर(stamp) के साथ मूल ओपीडी (OPD) पर्ची (slip).
4. पुरानी बीमारी प्रमाण पत्र (Chronic Disease certificate) की फोटोकॉपी
5. आवश्यक प्रमाण पत्र को पूरी तरह से अंतिम मूल वेतन (last basic pay) विवरण के साथ दर्ज किया जाना चाहिए
6. फार्म एयू 5/12 (Form AU5/12) पर मरीज की फोटो के साथ संलग्न किया जाना चाहिए जिसे संबंधित विभाग के एचओडी (HOD) / सक्षम प्राधिकारी (Competent Authority) द्वारा सत्यापित किया जाना चाहिए
7. दावेदार (Claimant) के संपर्क नंबर और I- कार्ड की प्रति(copy)।
8. निर्वहन सारांश (discharge summary) पर उपचार करने वाले डॉक्टर के हस्ताक्षर ।