SOUTHERN POWER DISTRIBUTION COMPANY OF TELANGANA LIMITED
(A Govt. of Telangana Undertaking)
6-1-50, Corporate Office, Mint Compound :: Hyderabad – 500 063, Ph.No.040-23431003/1032.

Claim for Reimbursement of Medical Charges For In-Patient Treatment

Check List to be signed and furnished by the TSSPDCL Employee

Indicate 'Yes' or 'NO' In the Brackets against each item.

1. **All the Columns of the application form have been filled in properly ( )**

2. **The bill has been submitted along with Essentiality Certificate 'A' for the treatment as Out-Patient by Furnishing all the particulars and signed by the Medical Attendant who treated the patient. ( )**

3. **The bill has been submitted along with the Essentiality Certificate 'B' for the treatment as In-patient by furnishing all the particulars and signed by the Medical Attendant who treated the patient and counter signed by the Head of the Hospital. ( )**

4. **The name of the disease has been indicated in the essentiality certificate in block letters. ( )**

5. **The period of Treatment has been specifically indicated in the essentiality certificate ( )**

6. **The case Doctor has signed on the essentiality certificate and countersigned by the Head of the Hospital. ( )**

7. **All the Columns of Essentiality Certificate 'A/B' have been filled in properly. ( )**

8. **All the cash receipts are within the period of treatment. ( )**

9. **The Cash receipts have been countersigned by the Doctor who treated the patient. ( )**

10. **The name of the patient and name of the Doctor has been indicted in all the cash receipts. ( )**

11. **All the cash receipts enclosed to the Medical Reimbursement claim are dated. ( )**

12. **The total amount of cash receipts tallied with the amount claimed. ( )**

13. **The duplicate bill with the copies of the original bills has been submitted. ( )**

(SIGNATURE OF THE EMPLOYEE)

Certificate to be furnished by the Forwarding Officer

1. **The bill is submitted within three months from the date of completion of treatment.**

2. **The application is as prescribed by the CPDCL.**

3. **The application from has been signed by the employee/countersigned by the controlling Officer with dates.**

4. **The name of the disease is indicated in Block Letters in the essentiality certificate certifying that it is a Chronic Disease.**

5. **The Medical Bill of the employee has been thoroughly scrutinized in the light of the instructions and guide-lines issued in pare 14 of Boards Memo No.DP/DM(A) F3/2487/85-16, Dt.25-4-89 and the statement is furnished.**

6. **The total amount of reimbursement so far sanctioned to the employee is Rs._____**

7. **Prior permission from the competent authority for taking treatment outside the state has been obtained in Memo. No…….. Date…….**

8. **The claim is within the powers of Member Secretary as per B.P.Ms.No.410, Dated.3-5-1989.**

9. **Proposal received in time i,e with in 3 months from the date of discharge i,e on _____**

ATTESTATION OF THE
FORWARDING OFFICER
(With Date and Designation)

(SIGNATURE OF THE CONTROLLING OFFICER)
(with Date & Designation)

FORM OF APPLICATION FOR MEDICAL CLAIMS

1. Name of the Employee. :
2. I.D.No & PPO. No :
3. Date of Birth. :
4. Father's Name. :
5. Designation and Basic Pay :
6. Section and office in which employed. :
7. Actual Residential Address. :
8. Office and place where wife/ husband is employed (if both are employed) :
9. Name of the patient and relationship (in case of children, state age also).
10. Name of the Medical Attendant and address and Name of the Hospital. :
11. Name of the disease in block letters. :
12. Period of treatment as in patient/ out patient as indicated in the Certificate. :
13. Details of Medical charges incurred Medical Attendance:-
    a) The No. and dates of consultations and fees paid for each consultation. :
    b) The No. and dates of injections and fees paid for each Injection. :
    c). Details of Laboratory tests X-Ray charges etc., :
    d) Cost of Medicines (Details of the consolidated medicines shall be furnished in the essentiality certificate). :
14. Hospital Treatment:-
    a) Accommodation Charges. :
    b) Diet Charges. :
    c) Lab charges (details shall be furnished).:
    d) Cost of Medicines supplied in the hospital.
    e) Surgeon's fee. :
    f) Asst Surgeon's fee :

Contd…..2

g) Anesthetist fee :

h) Theatre Charges :

i) Nursing charges :

j) Blood charges. :

15. Total amount claimed. :

16. Less advance taken on. :

17. Net amount claimed. :

18. No. of enclosures. :

19. Previously Availed (Yes / NO) :
(If Yes: CGM(HRD)/GM(IR&L)/AS(M&S)/PO(E)/ D.No.).

Declaration to be signed by the Employee

I hereby declare that the statements furnished above are true to the best of my knowledge and belief and the person for whom the above medical expenses were expenses were incurred is wholly dependent on me.

Place :

Date : SIGNATURE OF THE EMPLOYEE
(Ph.No. **)**

Countersigned and forwarded to Member Secretary/ Dr. Secretary (General Services) action.

(SIGNATURE OF THE CONTROLLING OFFICER)
(with Date & Designation)

Note:- The claim shall be supported by Essentiality certificate and cash receipts of the expenses shall be countersigned by the Doctor/Medical Officer.
All the cash receipts shall be within the period of treatment as indicated in the essentiality certificate. They must necessarily contain the name of the patient, name of doctor and date of issue.
The claims of the employees other than those opted for treatment at the
A.P.S.E.B/APCPDCL Dispensaries shall be only for chronic diseases like T.B. or other major operations and the same shall be indicated by the Doctor in the essentiality certificate.
All the medical Bills shall be submitted to their controlling Officers within three months from the last date of the treatment period who in turn after scrutiny, forward to the sanctioning authority as per the powers delegated in B.P.Ms.No.410 Dt.3.5.1989.

CERTIFICATE 'B'

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

Certificate granted to Mrs/Mr/Miss_____

Wife/Son/Daughter of Mr._____

Employed in the _____

PART – 'A'

(To be signed by the Medical Officer incharge of the _____

_____ case of the Hospital)

I, Dr_____hereby Certify.

(a) that the patient was admitted to Hospital on the advice of _____ (Name of the Medical Officer) on my advice.

(b) that the patient has been under treatment at _____ _____ and that the under mentioned.

Medicine 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 preparation for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants.

Sl. No.	Name of the Medicine	Price	Sl. No.	Name of the Medicine	Price

(c) that the injections administered were not for immunising prephylactic purposes.

(d) that the patient is/was suffering from_____ _____(Chronic/notchronic/major operation/minor operation) and is/was under treatment from _____ to _____ as in patient and from _____ to _____ as out patient.

Contd….2,

(e) that the X-ray laboratory tests etc. for which an expenditure of Rs._____ was incurred were necessary and were undertaken on my advice of _____

(f) the I called on Dr._____for specialist consultation and that the necessary approval of the _____ (name of the Chief Administrative Medical Officer of the State) as required under 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 _____ _____ 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
in charge of the case of the Hospital.

COUNTERSIGNED
Medical Superintendent

_____ Hospital.

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

Place :

Date : MEDICAL SUPERINTENDENT

Note: Certificates not applicable should be struck off.
Certificate(d) is compulsory and must be filled in by the Medical officer in all the cases. The name of the disease shall be followed by the word 'Chronic'/Major Operation for reimbursement of Medical charges as per Regulation 4(f) of the A.P.S.E.B Regulations for Reimbursement of Medical charges. The list of consolidated medicines shall be furnished in Block Letters.
The minimum facilities certificate may be signed either by the Medical Superintendent of the Hospital concerned or another Gazetted Medical Officer who has been authorized in this behalf by the Medical Superintendent.