NATIONAL INSTITUTE OF BIOLOGICALS  
(Ministry of Health & F.W.)

FORM OF APPLICATIONS FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND OR TREATMENT OF EMPLOYEE AND THEIR FAMILIES.

(FOR IN DOOR TREATMENT)

1. Name & Designation of NIB employees 
(IN BLOCK LETTERS)

   (i) Whether married or unmarried
   (ii) If married, the place where wife/Husband is employed

2. Office in which employed

3. Pay of the Govt. servant as defined in the Fundamental Rules 
   And any other emoluments which should be shown separately

4. Place of duty

5. Actual residential address

6. Name of the patient and his/her relationship to the NIB employees:

7. Place at which the patient fell ill

HOSPITAL TREATMENT

Name of the hospital

Charges for hospital treatment, indication separately the

Charges for

   (i) Accommodation (State whether if was according to status 
       or pay of the government servant and in case where the 
       accommodation is higher than the status of the government 
       servant, a certificate should be attached to the effect that 
       the accommodation (to which he was entitled was not 
       available).

   (ii) Diet

   (iii) Surgical operation or medical treatment or confinement

   (iv) Pathological, Bacteriological, Radiological or other 
        Similar tests. 
        Indicating

        (a) The name of the hospital or laboratory at which 
            Undertaken; and

        (b) Whether undertaken on the advice of the Medical 
            Officer in charge of the case at the hospital. If so, 
            A certificate or that effect should be attached

(v) Medicine

(vi) Special medicine (cash memos and the
(vii) Ordinary Nursing

(viii) Special Nursing i.e. Nurses specially engaged for the Patient, State whether they are employed on the advice of the Medical Officer in charges of the case at the Hospital or at the request of the government servant or Patient. In the former case a certificate from the M.O. In-charge of the case and countersigned by the M.S. Of the Hospital should be attached.

(ix) Ambulance charges
(State the journey – to and fro undertaken)

(x) Any other charges, e.g. charges for electric light, fan heater A/C etc. State also whether the facilities referred to are a part of the facilities normally provided to all Patients and no choice was left to the patient

Consultation with Specialist

Fee paid to a Specialist or a M.O. other than the Authorized Medical Attendant, indicating

(a) The name and designation of the specialist or M.O. consulted and the hospital to which attached

(b) Number and date of consultation and the fees charged for each consultation

© whether consultation was had at the hospital at the consulting room of the specialist or M.O.
Or at the residence of the Patient; and

9. Total amount claimed
10. Less advance taken on
11. Net amount claimed
12. List of enclosures

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

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

Dated: __________________________
Signature of the Government Servant and office to which attached.