NON DRAWL CERTIFICATE

(service employees)

(As per instructions issued in C & DSE, A.P., Hyderabad Procs. Rc.No. 8878/D3-4/2009, dated: 02-09-2009)

This is to certify that, the amount of Rs._____=00 (Rupees (Rupees_____ only) is being claimed now in this bill by SRI._____ , SGT/School Assistant ( ),_____,_____ Mandal, _____ District has not been paid previously towards Medical Reimbursement in respect of SRI._____ 0 (Self/ dependent), age (___) who has undergone the Treatment for the disease_____ during the period from_____to_____ in the Recognized Hospital By the Andhra Pradesh State Government i.e., at_____(hospital) as per the records available regarding the Medical Reimbursement defined under the Government Medical Attendance Rules, 1972

A note to that effect has also been made in the records of the school.

Signature of the
Government Servant.

Signature of the
Drawing & Disbursing Officer.

APPENDIX-II

APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE & OR TREATMENT OF GOVERNMENT SERVANT

1.	Name & Designation of the Government Servant/Retired (in block letters)	:	
2.	Office in which employed	:	
3.	Pay of the Government Servant as defined in FRs and other emoluments which should be shown separately	:	
4.	Place o Duty	:	
5.	Full Residential Address with Door.No. & Name of the Mohalla	:	
6.	Name of the Patient & his/her Relationship to the Government Servant. In case of children state age also	:	
7.	Place at which the patient fell ill	:	
8.	Nature of illness and its duration	:	
9.	Details of amount claimed cost of Medicines purchased from the Market/List of medicines, cash Memos and the Essentiality Certificate should be attached Each in Duplicate Signed by Treatment Doctor	:	
10.	Total amount Claimed	:	
11.	List of enclosures	:	

DECLARATION BY THE GOVERNMENT SERVANT

I Hereby Declare That The Contents In This Application Are True To The Best of my knowledge and belief and that the medical expenses are incurred for self as defined under the Andhra Pradesh Government Medical Attendance Rules 1972 and wholly dependent upon me

SIGNATURE OF THE GOVERNMENT SERVANT

SIGNATURE OF THE FORWARDING AUTHORITY AND STAMP

Date:

Place:

To

The, HM/ MEO

Mandal,
District.

Sir,

Sub: Request to sanction the Medical Reimbursement in repect of SRI._____,SGT/SA ( ),_____,_____ Mandal, _____District - Proposals submitted - Reg.

Ref: 1. G.O. Ms.No. 74, M&H Dept., dated: 15-03-2005.
2. G.O. Ms.No. 105, M&H Dept., dated: 09-04-2007.
3. Medical Bills issued by the Doctor concerned.

-o0o-

With reference to the subject cited, I submit here with the Medical Bills with all the enclosures for Medical Reimbursement for an amount of Rs._____=00 (Rupees (Rupees_____ only), as I have undergone Treatment for the disease _____ in the Recognised Hospital by the Andhra Pradesh State Government i.e., at _____ during the period from_____ to _____ and onward transmit to the higher authorities for further necessary action in the matter at an early date.

Thanking you sir,

Yours Faithfully

Signature of the employee

Encl:-
Essentiality Certificate
Emergency Certificate
Discharge summary
I.P Finalbill
Medical Bills
Appendix –II
Check List
Non Drawl Certificate
Dependent certificate
PPO copy(if pensioner)
Death certificate and family member certificate (if employee death)

CHECK SLIPS FOR SENDING MEDICAL REIMBURSMENT PROPOSALS

1.	Name and Official Address of the teacher	:	
2	If Retired a) Date/Year of Retirement b) Designation c) P.P.No.	:	
3.	Communication of Applicant, Address for all purpose with Phone No.	:	
4.	Name & Address of the Hospital & Dates of Treatment a) Whether it is Private Hospital (or) Recognized Hospital b) Whether referral letter produced (or) Recognized orders to be enclosed alongwith proposal.	: :	YES / NO YES / NO
5.	Whether the Medical Reimbursement Proposal is received in the Head Office within a period of Six Months from the date of discharge.	:	
6.	Whether the following are enclosed or not	:	
1)	Appendix-II duly attested by the forwarding authority.	:	YES / NO
2)	Non-Drawal Certificate in Prescribed Proforma	:	YES / NO
3)	In case Retired complete set of Pension Payment Order copy duly attested by the forwarding authority	:	YES / NO
4)	Emergency Certificate	:	YES / NO
5)	Essentiality Certificate	:	YES / NO
6)	Discharge Summary	:	YES / NO
7)	In case Dependent: Dependent Certificate	:	YES / NO
7.	If the patient is dependent on the Govt Employee in case of dependents above the age of 18 years Un-Employee Certificate and Marital Status of dependent are to be enclosed with Medical Reimbursement Proposal	:	YES / NO
8.	In case of the dependent of deceased Govt. Employee / Retired Employee whether Death & Legal Heir certificate enclosed or not	:	YES / NO
9.	Whether the Medical Reimbursement Proposal is prepared & submitted with reference to G.O.Ms.No. 74 HM & FW (K1) Dept, dt: 15.03.2005 & G.O.Ms.No. 60 HM & FW (K1) Dept, dt: 15.10.2003, & G.O.Ms.No. 105 HM & FW (K1) Dept, dt: 09.04.2007, G.O.Ms.No. 180 HM & FW (K1) Dept, dt: 11.05.2006.	:	YES / NO
10	Whether the Medical Reimbursement claim in processed through the drawing officer and received within the stipulated time.	:	YES / NO
11	And whether the availament of No. of installments recorded (or) not	:	YES / NO
12	Whether an entry is made in the service Register (or) not for previous claim and drawal.	:	YES / NO

I _____ (Full Name & Designation) here be declare that my Father/Mother/Son/Daughter _____ has no properly or income of his/her own and that he/she is wholly dependent on me as per APIMA Rules 1972.

Signature of the Government Servant **Signature of Forwarding Authority**

Government of Andhra Pradesh
School Education Department

From

To,
The Commissioner of School Education,
Ibrahimpatnam, Vijayawada,
Andhra Pradesh, Amaravathi.

Lr. No: …… …….., Dated :……...

Sir/Madam,

Sub: Submission of MR Bills of …….
Request for scrutiny and sanctioning of admissible amount - Reg.

*****

The details of Medical Reimbursement bills submitted to you for scrutiny and sanctioning of admissible amount as per the existing G.O's are as follows:

Name of the beneficiary (Patient) :-
Name of the Employee/Pensioner:-
Relation with beneficiary :-
Claim submitted by :-

Name	Relation with Employee/Pensioner

Name of the Hospital :-
Whether approved by DME or not:- Yes ○ No ○
Date of Admission: DD/MM/YY ☐☐/☐☐/☐☐
Date of Discharge: DD/MM/YY ☐☐/☐☐/☐☐

Amount Claimed :- Rs……

I certify that I have physically verified the following documents submitted by the Employee/Pensioner and found correct. I also certified that the original bills are kept under my safe custody until the sanction of the bill and when ever asked I will submit the original bills to O/o CSE, AP, Amaravathi.

- ☐ *Appendix-II*
- ☐ *Non-drawl Certificate*
- ☐ *Dependent certificate*
- ☐ *Emergency certificate*
- ☐ *Essentiality certificate*
- ☐ *IP/OP Bills*
- ☐ *Consolidated IP/OP Bills*
- ☐ *Original discharge summary/Death summary (in case of death of the Beneficiary during treatment.)*
- ☐ *Copy of DME approved proceedings (in case of approved hospital)*
- ☐ *Pension payment order in case of pensioners*
- ☐ *Any other relevant documents*

Station: Signature of DDO with seal
Date:

DEPENDENT CERTIFICATE GIVEN BY THE GOVERNMENT SERVANT

(As per instructions issued in C & DSE, A.P., Hyderabad Procs. Rc.No. 8878/D3-4/2009, dated: 02-09-2009)

I, SRI._____ _SGT/, School Assistant ( ),_____School_____Mandal,_____ District, do hereby declare that, My Dependent of Sri_____., age ( ) Years is my **Son/Daughter/mother/father/husband** and has no property of income of his own and that, he/she is wholly dependent on me only, he is also not a Employee or Pensioner.

Signature of the
Government Servant.

Signature of the
Drawing & Disbursing Officer.

MEDICAL REIMBURSEMENT FORM

Employee Details		
Emp Type:	**Emp Id**:	**Name**:
Email:	**Mobile Number**:	**Employee Designation**:

Address Details		
Residential Address:		
House No:	**Street No**:	**State**:
District:	**Villages/Cities/Towns**:	
Office Address:		
House No:	**Street No**:	**State**:
District:	**Villages/Cities/Towns**:	

Employee Pay Details		
Pay Source:	**PRC**:	**State**:

POSTING DETAILS		
HOD Name:	**DDO Code**:	**District**:

Treatment Details		
Treatments For:	**Patient Name**:	**Patient Gender**:
Patient Date Of Birth:	**Age**:	**Relation With Employee**:
Hospital Name:	**Hospital State**:	**Hospital Distric**:
Date Of Admission:	**Date Of Discharge**:	**Total Amount Claimed**:
Is Hypertensive:	**Is Diabetic**:	

Declaration

I hereby declare that the statement in the application is true to the best of my knowledge and belief and that the person from whom medical expenses were incurred is a member of my family as defined under the Government servant Medical attendance rules 1972 and wholly dependent upon me.

Signature of DDO

with Office Seal

Signature of Employee/Pensioner

3) THE DDO IS INSTRUCTED TO SUBMIT THE FOLLOWING DOCUMENTS .

i.	Emergency Certificate issued by the Hospital/ Referral letter from the teaching hospital concerned.	Issued by hospital
ii.	Essentiality Certificate issued by the Hospital concerned	Issued by hospital
iii.	Discharge Summary record / Death Summary record	Issued by hospital
iv.	Medical Bills	Issued by hospital
v.	I.P Final Bill	Issued by hospital
vi.	He / She has undergone treatment in recognized hospital vide DME Procs. No.	Issued by hospital
vii.	The Application of the incumbent in Appendix II	print
Viii	Check list	print
Ix	Non drawl certificate (service)	print
X	Non drawl certificate (pensioner)	print
Xi	Dependent certificate in respect of parents	print
xii	P.P.O.Copy all pages	
xiii	Death and family members certificate, Legal Hair Certificate, NOC certificate	Issued by concerned MRO and Municipality officers

NOTE :-

SUBMIT THE PROPOSALS ABOVE RS 50,000/- BILLS TO THE COMMISSIONER OF SCHOOL EDUCATION,A.P,IBRAHIMPATNAM VIJAYAWADA AMARAVATHI THROUGH DDO(DYEO/MPDO/MEO/HM) CONCERNED.