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

Certificate to be furnished by the Forwarding Officer

CHECK LIST

Sl. No.	DOCUMENTS	YES/ NO	Pages
1	RECOGNISED HOSPITAL AND BRANCH WITH SL.NO. Mentioned in Covering Letter		
2	CANDIDATE APPLICATION WITH STAMP & DATE COMPULSORY		
3	ESSENTIALITY CERTIFICATE (if Form-B all columns filled by doctor with sign & Hospital Stamp)		
4	EMERGENCY CERTIFICATE (Except EYE & Dental)		
5	DISCHARGE SUMMARY		
6	HOSPITAL FINAL BILL (Claim Amount) & BREAK-UPs		
7	CASH RECEIPTS WITH PAID BY EMPLOYEE SIGNATURE OF ALL RECEIPTS (Above Rs.5,000/- Revenue Stamp with sign)		
8	PPO COPY /ARTISAN Order Copy		
9	CLAIM FORMAT WITH THROUGH PROPER CHANNEL		
10	CONTROLLING OFFICER SIGNATURE & DATE COMPULSARY		
11	FAMILY DEPENDENCY/DECLARATION WITH EMPLOYEE & CONTROLLING OFFICER SIGNATURE in Medical Software.		
12	SPOUSE UNDERTAKING WITH CONTROLLING OFFICER SIGNATURE (IF ANY)		
13	OTHER BILLS STATEMENT (Date, Receipt No., Amount).		
14	IN CASE OF CHILD - AGE PROOF ONLY - BIRTH CERTIFICATE/ SSC MEMO(Other documents are not accepted).		
15	BILLS CLAIMED BY SON/DAUGHTER (NOT SPOUSE) LEGAL HAIR & AFFIDAVIT (NO OBJECTION FROM OTHER CHILDRENS WITH BOND PAPER).		
16	Declaration of Dependency Certificate		
17	Non Drawal Declaration Certificate attested by concerned Controlling & Disbursing Officer.		

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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)

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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**within three months** from the date of discharge i,e on _____.

Place : **ATTESTATION OF THE**
Date : **FORWARDING OFFICER**
(Designation& Departmental
Ph.No._____)

(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. Spouse Occupation :

9. Write the place of working&Department name (if both are employed) :

10. Name of the patient and relationship (in case of children, Birth/SSC). :

11. Name of the Hospital Name and Address.

12. Name of the Disease & IP No. :

13. Period of treatment indicate the D.o.A&D.o.D. :

14. Hospital Treatment:-

    a) Accommodation Charges. :
    b) Consultations 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 :
    g) Anesthetist fee :
    h) Theatre Charges :
    i) Nursing charges :
    j) Blood charges. :
    k) Total of Other Bills :

    (Enclose the Statement in Other Bills with Break-ups)

15. Total amount claimed. :

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16. Less Discount :

17. Net amount claimed. :

18. No. of enclosures. :

19. Previously Availed (Yes / NO) :
(If Yes: JS(IR&M)/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 incurred is wholly dependent on me and If anything proved wrong from the above declaration, I am solely held responsible.

Place : **SIGNATURE OF THE EMPLOYEE**

Date : (**Ph.No**._____)

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

(SIGNATURE OF THE CONTROLLING OFFICER)

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 essentialitycertificate.
All the medical Bills shall be submitted to their controlling Officers within threemonths 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.