Government of India
Department of Atomic Energy
Nuclear Fuel Complex

Application for reimbursement of Medicines

Date: .....

Pl. put tick mark (√):	**Homeopathy**		**Ayurvedic**		**Allopathy**	

To:
APO (CHSS), NFC, Hyderabad.

DETAILS OF EMPLOYEE & PATIENT

Employee Name (Shri/Smt./Kum):		Employee Status: (In-Service/Retired/Deceased)	
Employee No.:		Designation:	
Unit Name:		Basic Pay / Last Pay drawn:	
Patient Name:		Relationship with Employee:	
CHSS No. of Patient:		Validity of Patient CHSS Card:	
Address:		Mobile No.:	

HOSPITAL/AMA DETAILS

Hospital Name/AMA Name:		Doctor Name:	
Treatment from Date:		AMA Code:	
Treatment to Date:		Total Amount incurred:	

THE FOLLOWING DOCUMENTS ARE ENCLOSED

S No	**Documents**	**Yes/No**
1	Non availability certificate in case of Allopathy	
2	Prescription(s) copy	
3	Cash Bills in original	
4	Copy of CHSS card of the Patient	
5	Bank passbook copy/Cancelled cheque or Copy (For retired employees only)	

PRE STAMPED RECEIPT (FOR RETIRED EMPLOYEES) & DECLARATION

Received a sum of Rs._____ from Accounts Officer, NFC towards reimbursement of the Medical claim submitted by the undersigned.

I hereby declare that the statements in this application are true to the best of my knowledge and belief and further I declare that the treatment in Allopathic or in any other forms of medicine have not been taken for the same medical problems during the period of treatment mentioned above. I know the consequences of taking treatment simultaneously for the same medical problem, such as disallowing the claims and in addition any other action that may be taken against me.

Signature of the Prime Beneficiary

Certificate granted to the above patient who was suffering from _____ and was under my treatment from _____ to _____ and the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in condition of the patient. The medicines are not stocked in my hospital for supply to private patient and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparation which are primarily foods, toiletries or disinfectants.

S No.	**Name of the Medicines**	**Quantity**	**Amount (Rs.)**

Signature of the Doctor and Hospital stamp