

**CSIR-NATIONAL AEROSPACE LABORATORIES
BENGALURU-17**

No.All/Bills/2024-25

31st July, 2024

CIRCULAR

Sub: Revised Guidelines and Medical Claim Forms for purchase of medicines and OPD Treatment in r/o Employees / Pensioners and their dependent family members

It is proposed to introduce revised medical claims forms which are appended herewith in respect of reimbursement for outpatient treatment and purchase of medicines by the Employees / Pensioners and their dependent family members.

The following are the SOPs to be followed before submission of the claim forms **w.e.f. 01-08-2024.**


- a) The forms are in editable format and Employees / Pensioners may submit the duly filled in claim forms to the concerned Medical Officer to process at their end.
- b) The medical reimbursement forms have to be submitted once in three months along with prescription(s) given by the treating Doctor(s) and supporting bills towards purchase of medicines. The forms are available in NAL Intranet and also on NAL website (www.nal.res.in).
- c) The bills and prescriptions pertaining to only one individual beneficiary can be submitted in one form i.e., separate forms are to be used for different individuals / beneficiaries of the same family.
- d) The prescription to purchase medicines should be issued by the NAL Doctor or by any treating Registered Medical Practitioner (Allopathy) during leave, emergency or on discharge from the hospital, subject to prevailing guidelines.
- e) The expenditure incurred for the Investigations, Procedures or any Specialist Consultation shall be eligible for claiming reimbursement using this form, only if the Investigation, Special Consultation and Procedures are issued by the NAL Doctor during consultation at NAL. The Investigations, Procedures and cross referrals to other specialities within or outside the hospital, if any, shall be admissible if the treating specialist advises so and is endorsed in the prescription.



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- f) After signature of the Medical Officer, the Employees / Pensioners may drop the medical reimbursement forms in the drop-boxes, which are located at dispensary and Bills Section in Kodihalli and Belur Campuses respectively.
- g) In the reimbursement form, Employees / Pensioners have to mention Consultation / Test / Procedure in the chronological order as per bills and prescriptions attached') to enable Medical Officers to process the same at their end.
- h) The Co-operation of Employees / Pensioners and their dependent family members is requested for smooth functioning of the dispensary.

This issues with the approval of the Director.


(D MAYURA)
Administrative Officer

Copy To:

- 1. CMO
- 2. Head, DTS: With a request to kindly host the Circular and the forms on Intranet under "NAL Forms" and "Health Centre".

**NATIONAL AEROSPACE LABORATORIES, BENGALURU
HEALTH CENTRE**

Medical Reimbursement Form

Health Centre Card No

Emp. Name _____ Gr./Des _____ Divn./Sec _____ Basic Pay _____

Patient's Name _____ Relationship _____ Age _____

Period: Apr 24 to Jun 24

Reimbursement claim for the following medicines:

Sl. No	Name of the Medicine purchased (in block letters)	Quantity	Bill date	Admissibility (by MO-NAL)	Claimed		Admitted (for office use)	
					Rs	Ps		
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
Total								

Certificate

- ❖ I, Dr. certify that the above mentioned patient has been under my treatment & he/ she was required to have the above medicines which are essential for his/ her recovery/prevention of serious deterioration in condition of his/her health.
- ❖ The patient was suffering from
- ❖ The medicines at Ser No (if any) was advised by treating specialist.
- ❖ The patient did not require hospitalisation.
- ❖ The case is/was not one of prolonged treatment.

Bengaluru

Date: __/__/____

Signature of the Medical Officer

Declaration

I hereby declare that the statements made above are true to the best of my knowledge and belief and that the person for whom the medical expensed were incurred is wholly dependent on me and not in receipt of Rs 9000 pa. I also certify that the above medical bills are not claimed anywhere else either by self or by any other member thereof. I also undertake to refund the excess payments made, if any detected during post audit.

Date: __/__/____

No. of Cash bills attached

Signature of Council Servant

Claim passed for payment for Rs: (Rupees

Verified by Administration :

Test-Checked by Finance & Accounts :

Receipt

Received a sum of Rs: (Rupees

Bengaluru

Date: __/__/____

(to be signed at the time of receiving payment)

Signature of the Council Servant

**NATIONAL AEROSPACE LABORATORIES, BENGALURU
HEALTH CENTRE**

Health Centre Card No

Name Gr./Des Divn./Sec Basic Pay

Patient Name Relationship Age

Reimbursement claim for the following tests/ Investigations:

Period: Apr 24 to Jun 24

Sl. No	Consultancy/ Tests/ Procedure	Bill date	Speciality (if Any)	Hospital/ Lab	Admissibility (by MO-NAL)	Amount Claimed	Amount admitted
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
Total							
Signature of MO-NAL							

❖ The patient was suffering from/ reason for recommendation:

❖ The investigations/ procedures at Ser No (if any) was advised by treating specialist. (Enclosed)

Bengaluru
Date: __/__/____

Signature of the Medical Officer

Declaration

I Hereby declare that the statements made above are true to the best of my knowledge and belief and that the person for whom the medical expensed were incurred is wholly dependent on me and not in receipt of Rs 9000 pa. I also certify that the above medical bills are not claimed anywhere else either by self or by any other member thereof.

Bengaluru
Date: __/__/____

Signature of Council Servant