

HARYANA POWER GENERATION CORPORATION LIMITED
(ESSENTIALLY CERTIFICATE)

Name of Employee / Claimant/ Pensioner	
Employee HRMS code/PPO No./Employee Code	
PAN No.	
Basic pay/basic pension	
Designation	
Office in which employed	
Name of Patient	
Residential Address of employee/Retiree	
Patient Card no.	
Relationship of patient with claimant	
Period of treatment	
Name of Bank and address (same where pay or pension is being disbursed): -	
IFSC code:	
Account No.:	
Indoor Ticket no.	

In case treatment taken under Cashless Policy: -

Name of claimant Hospital	
Treasury unique code	

Certified that the above named patient has been under my treatment in dispensary/Hospital for _____. The under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration the condition of the patient. The medicines are not stocked In the Hospital (for supply to the patients) and do not include proprietary preparation for which cheaper substance of equal therapeutic value is available or preparation which are primarily food, toiletry or disinfectant. Certified that:

1. The medicines have no cheaper effective substitute.
2. The treatment given was Indoor/Outdoor
3. The price claimed is reasonable.
4. The medicines are not in the form of tonic food or vitamins, the cost of which is not reimbursable in govt. orders Issued on the subject from time to time.
5. The patient was suffering from_____

Sr. No	Name & quantity of medicines	Outdoor/indoor ticket No. & date of prescription	Dato on which actually purchased	Amount (In Rs)

In case of indoor treatment: -

Certified that the medicines claimed in this bill are as per Ticket no: _____ which relates to the case.

Signature of AMA
(Name in Block Letters)
PTO

Certified that:

1. The medicines have actually been purchased by me during the course of treatment.
2. I have fully utilized the purchased medicines during the course of treatment (In case medicines purchased more than one month).
3. I am not drawing fixed cash medical allowance.
4. In case Spouse is not employed /working:
5. The patient is my spouse and he/she is wholly dependent up to me and is residing with me.
6. In case of children:
The patient is my child and he/she is wholly dependent upon me and is residing with me and he/she is unmarried & unemployed. His/her monthly income does not exceed Rs 3500/-
7. For parents only:
The parents are wholly dependent upon me and residing with me. The monthly income of my parents does not exceed Rs 3500/.
8. In case spouse is working:
 - A) My spouse is not getting fixed cash medical allowance from any source.
 - B) My spouse is employed and is not getting any medical reimbursement. Affidavit to this effect has already been furnished is being attached.
9. I am not an ad-hoc employee but working on regular basis.

Signature of Claimant

Full Name: _____

Designation: _____

Office/ Department _____

Mobile NO • _____

Dated: _____

Encl.

1. Discharge summary & countersignatures by Medical Superintendent of respective hospital (in case of Indoor treatment).
2. Countersignatures by Medical Superintendent of respective hospital where amount exceeds Rs. 25000/- (in case of Outdoor treatment).
3. Prescription Slip by Doctor (in case of Outdoor treatment)
4. Emergency Certificate in case of treatment taken from unapproved private hospital.
5. Photocopy of PAN Card.
6. Photocopy of Passbook/Cancelled Cheque (Name of Bank with Account No. and IFSC Code).
7. Photocopy of Medical Facility order issued by HPGCL.