ESSENTIALITY CERTIFICATE
(To be filled in capital letters)

Name of Claimant _____ Period of Treatment _____

Designation _____ From _____ to _____

Department _____ Indoor No. _____ Date _____

Pay _____ Outdoor No. _____ Date _____

I certified that Mr./Mrs./ _____ Father /Mother/Husband/Wife/Son/Daughter of _____ employed in the office of the _____ Hospital/dispensary in my consultation and that under mentioned medicines prescribed by me in this connection was absolutely essential in the condition of the patient. The medicines were not stocked in the _____(name of Hospital/Dispensary) for the supply to the patient and do not include preparation for which cheaper institute of equal therapeutic value are available / not the preparation prescribed are primarily food, toilet or dependents.

1. Certified that medicines have no cheaper and elective substitute.
2. Certified that the treatment given was indoor/outdoor.
3. Certified that the price claimed is reasonable.
4. Certified that the medicines are not in the nature of tonics or food or vitamins etc, the cost of which is not reimbursable in the Govt. orders issued on this subject from time to time.
5. He/She is suffering from _____ (In capital letters)

Sr. No.	Name & Quantity of medicines in Capital Letters	Outdoor Ticket No. & Date on which prescribed	Date on which actually purchased	Price Rs. P.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

16.				
17.				
18.				
19.				
20.				

Signature and Designation of
Authorized Medical Attendant

In case of indoor Treatment:

Certified that the medicines claimed in this bill by me as hand ticket No_____relates to the case.

Signature and Designation of
Authorized Medical Attendant

Certified that

1. The medicines have actually been purchased by me during the course of treatment.
2. I am living in the House No. _____
3. I have purchased the medicines from the prescribed co-operative store.
4. The medicines have been purchased from private shop after obtaining no availability certificate from co-operative store / Super Bazar_____
5. The amount of medicines purchased from private shop against one or more prescription does not exceed Rs. 50/- in a single day.
6. In case of wife/children:-
   That the patient Mr./Mrs. _____is my _____ and he/she is wholly dependent upon me and is residing with me and he/she is unmarried and un-employed (in case of son/daughters).
7. For parents only:-
   His/her total monthly income does not exceed Rs. 3500/- PM and my mother/father is/are residing with me.
8. In case spouse & working:-
   a. Certified that my wife/husband is not getting any fixed medical allowance from any source.
   b. Certified that my wife/husband is employed and is not getting any medical re-imbursement. An affidavit to this effect has been furnished.
   c. Certified that I am not adhoc employee and I am working on regular basis.

Signature of the Claimant

Name of Claimant_____

Designation_____

Employee Code_____

Contact No._____

Place: _____

Date:_____