

**FROM “ D<sub>2</sub> “**  
Essentiality Certificate-cum Statement of Expenditure Certified by Treating Specialist for Indoor / Day Care  
Treatment and related OPD Treatment  
[See sub-clause 12 (3) & clause 6, clause 7(2) & clause 9 ]

1. Name of the Government Employee with identification No. :
2. Name of office of the Government employee with address. :
3. Name of the patient, relationship with  
Govt. employee & Identification No. :

4. **Details of expenditure :**  
i) Name of the diagnosed disease :  
ii) Name and code No. of the empanelled /  
Govt. recognized hospital. :  
iii) Period of Indoor / Day Care Treatment :  
iv) Total No. of original vouchers & money receipt :  
v) **Details of Amount Claimed**

(A) for package treatment from \_\_\_\_\_ to \_\_\_\_\_

Sl No.	Procedure	Product Code No.	Amount Claimed (Rupees)	Amount Admissible (Rupees)
i				
ii				
iii				
iv				
v				

**Miscellaneous**  
( Specify & give details in separate sheet, if necessary

Total Rupees \_\_\_\_\_ only.

(B) for Non-Package treatment from \_\_\_\_\_ to \_\_\_\_\_

Sl No.	Description of items	Item Code	Amount Claimed	Amount admissible (for official use)
i	Room Rent: (a) Ward (b) ICU / ITU / CCU / NICU / PICU (C) HDU / Step Down Unit / Burn Unit			
ii	Charge for : (give details with code nos. in separate annexure ) (a) Indoor visit of specialist / super specialist (b) Radiological Investigations (c) Pathological Investigations (d) Medicines (e) Artificial devices (f) Miscellaneous (specify)			

Total : ( Rupees \_\_\_\_\_ only )

(vi) Related OPD treatment in terms of Clause-9 or Clause-7 (2)

Sl. No.	Description of items	Amount Claimed	Amount admissible (for official use)
i	Consultation fees (Indicate total no of consultation )		
ii	Charges for : (a) Pathological Investigations (b) Radiological Investigations (c) Medicines (d) Special devices like hearing aid / artificial appliances etc. (Specify ) (e) Miscellaneous (specify)		

Total : Rs. Rupees \_\_\_\_\_ only

Grand Total (Package + non-package + OPD amount) = Rupees \_\_\_\_\_ only

Signature of claimant

Name in Block Letter

Address

1. Certified that the relevant bills / vouchers have been verified by me in pursuance of the latest approved rates of the WBHS, 2008 and the expenditures shown above are correct and the treatment services prescribed and provided were essential and minimum that required for the recovery of the patient.
2. Certified that the services of special Nurse / Ayah were required from \_\_\_\_\_ to \_\_\_\_\_ that were absolutely essential for the recovery of the patient.
3. Specific procedure / Operation performed was \_\_\_\_\_ on \_\_\_\_\_.
4. Conservative treatment provided from \_\_\_\_\_ to \_\_\_\_\_.

Countersigned by  
Administrative officer/ Medical Superintendent of  
The empanelled / recognized Hospital With official seal

( Signature of the Treating Specialist with official seal )