प्रेषक,

डॉ. विदुषी सिंह,
प्रधान न्यायाधीश
परिवार न्यायालय, मथुरा ।

सेवा में,

श्रीमान महानिबन्धक,
माननीय उच्च न्यायालय
इलाहाबाद ।

पत्रांक संख्याः 846...../ पी.जे. दिनांकः 13 अप्रैल 2023

विषयः <u>चश्मा क्रय करने की धनराशि की प्रतिपूर्ति कराये जाने के सन्दर्भ में ।</u>

महोदय,

उपरोक्त विषयक माननीय न्यायालय को अवगत कराना है कि मेरे जिला अस्पताल मथुरा में नेत्र चिकित्सक से स्वयं की ऑखों का चैकअप कराया गया जिसमें चिकित्सक द्वारा चश्मा लगाये जाने का परामर्श दिया गया था । मेरे द्वारा चिकित्सक के परामर्श के अनुसार लाल चश्माघर भूतेश्वर, कृष्णा नगर मथुरा से मु० 14,000/–रूपये का चश्मा क्रय किया गया और चिकित्सा प्रतिपूर्ति देयक का मुख्य चिकित्साधिकारी, मथुरा की संस्तुति के उपरान्त स्वीकृति हेतु इस पत्र के साथ संलग्न कर माननीय न्यायालय को प्रेषित किया जा रहा है।

महोदय यह भी अवगत कराना है कि माननीय उच्च न्यायालय द्वारा तीन वर्ष में एक बार 15000/– रूपये तक की धनराशि जो चश्मा क्रय करने में व्यय की गयी हो, प्रतिपूर्ति किये जाने हेतु आदेश वर्ष 2016 में निर्गत किया गया था। मेरे द्वारा चश्मा क्रय की जाने वाली धनराशि की प्रतिपूर्ति का बिल दिनांक 20.02.2020 को तीन वर्ष पूर्व माननीय उच्च न्यायालय को स्वीकृति हेतु प्रस्तुत किया गया था, जो मुझे प्राप्त हो चुका है।

अतः माननीय महोदय से अनुरोध है कि उक्त आदेश के अन्तर्गत चश्मा क्रय की गयी धनराशि की प्रतिपूर्ति कराये जाने के लिए प्रतिपूर्ति देयक को माननीय न्यायालय के समक्ष स्वीकृत कराने हेतु प्रस्तुत करने की कृपा करें।

सादर ।

भवदीया,

13/4/23

(डॉ. विदुषी सिंह)
प्रधान न्यायाधीश
परिवार न्यायालय, मथुरा ।

दिनांक–13.04.2023

संलग्नकः यथोक्त

प्रधान न्यायाधीश
परिवार न्यायालय, मथुरा

स्वास्थ्य एवं परिवार कल्याण विभाग
उत्तर प्रदेश सरकार

प्रेषक,

प्रमाण पत्र संख्या:CMER2365163

Superintendent in Cheif / Chief Medical Superintendent, District Male Hospital
मथुरा।

सेवा में, **PRINCIPAL JUDGE**
FAMILY COURT MATHURA

पत्रांक : म्० चि० अ०/चि० प्र० **पूर्ति०/2023/0121579/MATHURA** /88 11/4/23
विषय : DR VIDUSHI SINGH की चिकित्सा व्यय प्रतिपूर्ति के सम्बन्ध में।

महोदय,

उपर्युक्त विषयक DR VIDUSHI SINGH के आवेदन पत्र संख्या MER0121579 दिनांक 31/03/2023 के क्रम में आपके पत्र संख्या MER0121579 दिनांक 28/03/2023 के संदर्भ मे अवगत कराना है कि DR VIDUSHI SINGH, SELF, DR VIDUSHI SINGH द्वारा चिकित्सा प्रतिष्ठान/संस्थान MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA में दिनांक 21/01/2023 से 24/03/2023 तक EYE PROBLEM रोग का उपचार कराया गया है, जिस पर हुए व्यय 14,000.00 के दावे की तकनीकी परीक्षण उपरान्त देय धनराशि को किये जाने हेतु प्रेषित किया गया, जिसे उत्तर प्रदेश शासन चिकित्सा अनुभाग–6 के उत्तर प्रदेश सरकारी सेवक (चिकित्सा परिचर्या) नियमावली–2011 की अधिसूचना संख्या : 2275/5–6–11–1082–07 दिनांक 20.09.2011 एवं उत्तर प्रदेश सरकारी सेवक (चिकित्सा परिचार्य) (प्रथम संशोधन) नियमावली–2014 की अधिसूचना संख्या रू 474/पाँच–6–14–1082 / 87 टीसी दिनांक 04 मार्च 2014 में निहित प्राविधानों के अन्तर्गत प्रदेश के अन्दर एस० जी० पी० जी० आई०, लखनऊ तथा प्रदेश के बाहर ए० आई० आई० एम० एम० (एम्स) नई दिल्ली की देय दरों के अनुसार तकनीकी परीक्षण कर देय धनराशि कुल 14,000.00 मात्र की धनराशि प्रतिपूर्ति हेतु संस्तुति की जाती है। अनिवार्यता प्रमाण पत्र तदनुसार प्रतिहस्ताक्षरित है।

पत्रांक : मु० चि० अ०/चि० प्र०
पूर्ति०/2023/0121579/MATHURA
प्रतिलिपि निम्नलिखित को सूचनार्थ प्रेषित

1.
2.
3.

दिनांक : **10/04/2023**
भवदीय

Superintendent in Cheif / Chief Medical Superintendent, District Male Hospital
मथुरा

Chief Medical Superintendent
District Hospital, Mathura

MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA

In Front Rangeswar Mandir Near Vikas Bazar Holi Gate , Mathura-281001, Mathura, Uttar Pradesh, India

CR No: **992032300114313** **OUT PATIENT CARD**

Patient Name: DR VIDUSHI SNGH	Age/Sex: 56 Yr/F
D/O: SHRI OM PRKASH SINGH	ABDM Health ID: NA
Address: Mathura,Uttar Pradesh,India Mobile: 9412210001	ABDM User ID :NA
Category: General	Fees: ₹1.00/-
Department/RoomNo: Ophthalmology / 23	OPD Days:Mon,Tue,Wed,Thu,Fri,Sat
Doctor/Unit: Ophthalmology General	Visit Date & Time: 21-Jan-2023 10:26
	Valid Till: 05-Feb-2023

Investigations to rule out glaucoma

- OCT
- Field Analysis

RE- +2.00 DC 100° 6/24
LE- +2.75DS/+2.25 DC 120° 6/18
Near Add +2.5 Both eye

Refer to higher centre as these investigations are not done at district hospital

चिकित्सा व्यय की प्रतिपूर्ति हेतु
(क) CERTIFICATE - A

(To be Completed in the case of patients who are not admitted in hospital for treatment)

Certificate granted to Mrs./Mr./Miss Dr. Vidushi Singh

wife/son/daughter of Mr. Lt. Shri Om Prakash

empioyed in the Mathura Judgeship

CERTIFICATE - A

(To be signed by the medical officer in-charge of the case at the hospital)

I Dr. ..... hereby certify.

(a) that I charged/received Rs. ..... for consultation on ..... at my consulting room/at the residence of the patient.

(b) that I charged and received Rs. ..... for administering ..... intramuscular/sub cutaneious injections on date ..... at my consulting room/ at the residence of the patient and the injection were for immunizing or prophylactic purposes.

(c) that the paient has been under treatment at ..... hospital/my consulting room and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious detenoration in the condition of the patient. The medicines are not stocked in the (name of the hospital) .... for the supply to private patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available and not preparations which are primarily foods, toilets and disinfectants.

Sl.	Name of medicines	Quantity	Price
1.			
2.	1- Receipt No- 70 Dated: 20.03.2023 Lal Chashma Ghar		Rs. 14,000/-
3.			
4.			
5.	Bill Attached.		
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Verified
Dr. KALPANA TIWARI
Eye Specialist
District Hospital, Mathura

(d) that the patient is/was suffering from ..... and is/was under my treatment from ..... to .....

415/416

GSTIN :-
09AFUPC6734Q2ZI

Sale Invoice
LENSCARD
mathura

Contact No.
9720065555

Party Name : VIDHUSHI SINGH
Mobile no: 7017557175
Address :

Receipt No : 70
Receipt Date : 20-03-2023
Delivery Date : 24-03-2023
Time : 12:06PM

Sn.	Particulars_detail	Qty	Price	Dis.	Amt
1	SHEET 5	1	5000.00	0.00	5000.00
2	CRIZAL PROG.	1	9000.00	0.00	9000.00
	Total Value				14000.00
	TAXABLE AMT				12500.00
	Total		2		14000.00

RIGHT EYE

	SPH	CYL	AXIS	V/N
DV	0.00	+2.00	100	6/
NV	+2.00	+2.00	100	N
ADD	+2.50			

LEFT EYE

	SPH	CYL	AXIS	V/N
DV	+2.75	+2.25	120	6/
NV	+5.25	+2.25	120	N
ADD	+2.00			

PD :
Refered By :

Total Invoice value (In Words) :
Fourteen Thousand Rupees Only
Terms & Condition :

Paid Amount : 14000.00
Due Amount : 0.00

For
LENSCARD

Dr. KALPANT TIWARI
Eye Specialist
District Hospital, Mathura

(e) that the patient is/was not given prenatal or postnatal treatment.

(f) that the X-Ray, Laboratory tests for which on expenditure of Rs. ..... was incurred were necessary and undertaken on my advice at .....

(g) that I referred the patient to Dr. ..... for specialist consultation and that the necessary approvial of the ..... as required under the rule was obtained.

(h) that the patient did not require hospitalisation.

Date .....

Signature and Designation of the Medical Officer-in-charge which of the case at the hospital

Dr. RAJ PAL SINGH
Eye Specialist
District Hospital, Mathura

COUNTERSIGNED

I certify that the patient has been under treatment at the ..... hospital and the facilities provided were the minimum which were essential for the patient's treatment.

कुल दावा धनराशि 14,000 =००

अदेय धनराशि .....

कुल देय धनराशि 14,००० =००

Place .....

Date ..... (fourteen Thousand Rs. only)

Medical Superintendent,
..... Hospital

Counter Signed

Chief Medical Superintendent
District Hospital, Mathura

Department of Medical Health and Family Welfare

Government of Uttar Pradesh

Online Application Form for Registration of Medical Reimbursement

To,

Application Number : MER0121579

The Superintendent in Cheif / Chief Medical Superintendent,
Distt : Mathura
Uttar Pradesh

Sir,

Kindly Register my request for issuance of Medical Reimbursement which are given as below:

1 Treatment Type:

Treatment Category	For OPD Treatment		

2 Employee's Detail:

Full Name	DR VIDUSHI SINGH	**Father Name**	LATE SHRI OM PRAKASH
Designation	PRINCIPAL JUDGE FAMILY COURT MATHURA	**Aadhaar No.**	421644932393
Date Of Birth	29/11/1966	**Gender**	Female
Mobile No	9412210001		

3 PPO detail:

Retired from Employeement	No

4 Address of Current Posting :

Office Name	FAMILY COURT MATHURA	**Office Incharge Name**	PRINCIPAL JUDGE FAMILY COURT MATHURA
Address	CIVIL COURT MATHURA	**State**	Uttar Pradesh

District	Mathura	Pincode	281001

5 Permanent Address :

Address	J 22 JUDGE COLONY CIVIL LINE MATHURA	State	Uttar Pradesh
District	Mathura	Pincode	281001

6 Patient`s Details:

Requesting Medical Reimbursement for	Self	Hospital Type	Govt
Patient Name	DR VIDUSHI SINGH	Age	56
Gender	Female	Disease Name	EYE PROBLEM
Place where Disease Identified	MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA	Hospital Name	MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA
Doctor Name	GOVT DOCTOR	Treatment Period From	21/01/2023
Treatment Period To	24/03/2023	Patient Aadhaar no	421644932393
Relations with Employee	Self		

7 Details of expenditure:

S.No.	Bill Type	Bill No.	Date	Amount	Download
1	Other	70	20/03/2023	14000.00	
			Total	14000.00	

8 Advance Detail:

Have you already taken Advance	No

9 Bank Details of Employee:

Bank Name	STATE BANK OF INDIA	**Branch Name**	MATHURA CANTT BRANCH
Account Number	41189732910	**IFSC Code**	SBIN0005716

Date	**Place**	**Signature of Person Incharge**

स्तम्भ-1

विद्वमान परिशिष्ट

परिशिष्ट 'ग'

भाग-पाँच-नियम 16 तथा 18 देखे

सेवा में,

PRINCIPAL JUDGE
CIVIL COURT MATHU
MATHURA, 281001

विषय- चिकित्सा उपचार पर किये गये व्यय की प्रतिपूर्ति।

महोदय,

मैं DR VIDUSHI SINGH ने EYE PROBLEM के लिये दिनांक 21/01/2023 से 24/03/2023 तक में MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA उपचार करवाया है। जिसका दावा रुपया 14,000.00 निम्नलिखित दस्तावेजों के साथ प्रतिपूर्ति के लिये दावा प्रस्तुत कर रहा हूं।

1. उपचारी चिकित्सक/चिकित्सालय के अधीक्षक द्वारा हस्ताक्षरित/प्रतिहस्ताक्षरित अनिवार्यता प्रमाण-पत्र ।
2. उपचारी चिकित्सक द्वारा विधिवत हस्ताक्षरित एवं सत्यापित मूल नकद पर्ची (कैश मेमो) बीजक (बिल) बाउचर।

उपरोक्त उपचार हेतु कोई अग्रिम राशि नहीं लिया गया है

DR VIDUSHI SINGH
PRINCIPAL JUDGE
FAMILY COURT

दिनांक

Certificate granted to **DR VIDUSHI SINGH, 56, FEMALE** of Mr employed In the

Certificate 'A'

(To be completed in the case of patient who are not admitted to hospital for treatment)

Dr hereby certify:-

(a) That I charged/received Rs **14,000.00** for consultations on **21/01/2023** at my consulting room at the residence for the patient.

(b) That the patient has been under treatment at **MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA** hospital/my Consulting room and that the under , mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient. The medicines are not socked in the **MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA** for the supply to private patients and do not include proprietory preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets and disinfectants.

Sl. NO	Particulars of Bills	Bill No	Bill Date	Amount
1	Other	70	20/03/2023	14,000.00

Rupees Fourteen Thousand Only

Total:-Rs. 14,000.00

(c) That the patient is/was suffering from **EYE PROBLEM** and is/was under my treatment form **21/01/2023** to **24/03/2023**

(d) That the patient is/was not given prenatal of postnatal treatment.

(e) That the X-Ray, Laboratory test, etc. for which an expenditure of Rs **0.00** was Incurred were necessary and were undertaken on my advice at **MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA**

(f) That I referred the patient to Dr.....for specialist consultation and that the necessary approval of the.....as required under the rules was obtained.

(g) The the patient did not require/required under the rules for hospitalization.

(h) I am not drawing any NPA/NPP.

Date:

(Signature and Seal)
MAHARSHI DAYANAND SARASWATI DISTRICT MALE HOSPITAL MATHURA

For Office Use Only

COUNTERSIGNED

I Certify that the patient has been under treatment at our Hospital/Dispensary and that the facilities provided were the minimum which were esential for the patient's treatment.

Date:

(Signature and Seal)
(Medical Suprintendent of the Hospital Or Dispensary or Authorised Signatory designated by Competant Authority)