INDIAN INSTITUTE OF TECHNOLOGY (BHU)

Medical Reimbursement Claim Form

(To be filled in by the serving / retired employees)

1. Name of the Employee.....(Mobile No.....)
2. Employee/CPF/NPS/PPO No.....(Date of retirement, if retired.....)
3. Designation & Department.....
4. Residential Address.....
5. Particulars of Patient
   (a) Patient's Name.....Age (DOB in case of Son/ Daughter).....
   (b) Relation with the employee.....
   (c) Patient Health Diary No.....
6. Particulars of Treatment
   (a) Name of the Hospital/Clinic.....
   (b) Name of the treating Consultant & Department.....
   .....
   (c) Disease Name.....
   (d) Whether OPD/IPD treatment.....
   (e) Period of the treatment for which the medical claim pertains, from.....to.....
7. Particulars of Claim.
   (a) Medical claim amount, Rs.....
   (b) T.A. for Self and Escort (if any), Rs.....
   (c) Total amount of Claim, Rs.....
8. LIST OF ENCLOSURES
   (a) Patient health diary front page photocopy.
   (b) In case of OPD treatment, consultation prescription/ relevant pages of health diary, photocopy.
   (c) Medicine dose list (as per format).
   (d) Statement of medical claim (as per format).
   (e) In case of IPD treatment, discharge certificate photocopy.
   (f) Cash memos in original.

Note: *In case of OPD treatment in UEHCC/ SSH/ Trauma Centre, BHU, 'NA' on the Health Diary is compulsory for medicines which are not available in UEHCC dispensary and only such medicines will be reimbursed.*

Contd...

DECLARATION BY THE EMPLOYEE

I Solemnly declare :

That the information furnished by me as indicated above is true and correct to the best of my knowledge and belief and if any information is found incorrect, I shall be held personally responsible. The Cash Memo included in the claim are Original/Genuine and pertain to the treatment of self/my family member eligible for such benefit as per rules and he/she is wholly dependent on me and ordinarily residing with me at Varanasi. No claim either in full or in part pertaining to the medical expenses on the treatment for this duration has been submitted earlier to the Institute or any other source for reimbursement, either by myself or the patient.

(Signature of the employee)

Name.....

Signature of the Head of the Department/ Office with Seal

Designation.....

Deptt.....

Date.....

FOR USE BY MEDICAL REIMBURSEMENT CELL, IIT (BHU)

(Major Head – ***Plan-OH-36(Recurring)*** & Minor Head – ***Medical treatment***)

1. Name of recipient : .....
2. Amount of total claim : Rs.....
3. Amount not admissible : Rs.....
4. Claim admitted for : Rs.....
5. Deduction of advance, if any : Rs.....
6. ***Passed for payment of Rs***.....

Asstt. Registrar/ Jt. Registrar
M.R. cell
IIT (BHU)

Junior Superintendent/Checker
M.R. Cell
IIT (BHU)

STATEMENT OF MEDICAL REIMBURSEMENT

(To be filled in by the serving / retired employees)

1. Name of the Employee:..... Employee/CPF/NPS/PPO No.....
2. Designation & Department.....
3. Period of the treatment for which the medical claim pertains, from.....to.....

Sl. No.	Name of the Shop/ Hospital/ Pathology lab etc.	Date	Cash Memo No.	Name of Medicines/ Investigation/ Consultation	Amount	Net Amount
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Signature of employee/Pensioner

Date:

Medicine dose list

(To be filled in by the serving / retired employees)

1. Name of the Employee:..... Employee/CPF/NPS/PPO No.....
2. Designation & Department.....
3. Period of the treatment for which the medical claim pertains, from.....to.....

Sl. No.	Name of the Medicine	Dose Prescribed	Qty. of Medicine Purchased	Admissible as per prescribed	Excess Qty. Purchased

Signature of employee/Pensioner

Department: