भारतीय प्रौद्योगिकी संस्थान गुवाहाटी

INDIAN INSTITUTE OF TECHNOLOGY GUWAHATI

Medical Claim Form

Application for claiming refund of medical expenses incurred in connection with medical attendance and treatment of students, members of staff of the Indian Institute of Technology and their families. (N.B. separate form should be used for each patient)

Total no. of sheets including this:=

***I. Status Information for the claimant (in Block Letters) -**

a) Name (IN BLOCK LETTERS) :

b) Designation with Emp No./Roll No. :

c) Department/ Section/ Centre/ Cell :

d) Pay (In case of employee) :

e) Bank A/c no., IFSC, Bank name and branch :

f) Residential Address

II. Information regarding the patient:

a) Name of the Patient & Relationship :

b) Illness :

c) Since when ill & place where ill :

III. Amount claimed and details thereof:

a) **Number and dates of consultation and the fee paid for each consultation**

(i) Date of Consultation :

(ii) Fee paid for each visit :

b) Name & Designation of Medical Officer consulted :

c) Hospital/ Dispensary attached :

d) Whether consulted at Hospital/ consulting Room of Doctor/ Residence :

e) Fee paid for each consultation :

indicates mandatory information

IV. Charges for Pathological, Bacteriological, Radiological or other similar tests undertaken, during diagnosis indicating:

a) Name of Hospital or Laboratory where tests undertaken :

b) Whether tests undertaken on advice of the authorized Medical Attendant (If so, attach certificate) :

1. c) Cost of Medicines purchased from market (List and cash memos to be attached) as also essentiality certificate countersigned by_____ :

(i) No. of Cash Memos attached (*** Please submit Cash Memo/ Bills in original only)** :

Total amount claimed (in ₹) :

Total Number of enclosures :

DECLARATION TO BE SIGNED BY THE EMPLOYEE/STUDENT

I hereby declare that the statement made in this application are true to the best of my knowledge and belief/ and that the person for whom medical expenses were incurred is wholly dependent upon me and is not an earning member of the family.

Date: _____

Signature

Contact no. ……

e- mail id(@iitg.ac.in)…….

Countersigned and certified that the claim:

i) is genuine
ii) is covered by the rules and orders on the subject
iii) is supported by bills, receipts and other certificates etc.
iv) was not drawn before and
v) has been sanctioned by me.

Joint Registrar/Assistant Registrar (F&A)

***Indicates mandatory requirement**

FOR OPD TREATMENT ONLY

ESSENTIALITY CERTIFICATE "A"

Certificate granted to Mr./Mrs./Miss/_____wife / husband/ father/ mother/ son/ daughter_____ employed in the IIT Guwahati.

1. Dr._____ hereby certify

a). That I charged and received Rs._____ for consultations on _____ at my consulting room/ at the residence of the patient.

b). That I charged and received Rs._____ for administering intramascular/ sub-cutanreous_____ at many consulting room/ at the residence of the patient.

c). That the injections administered were for / were not for immunizing or prophylactic.

d). That the patient 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 deterioration in the condition of the patient. The medicines are not stocked in the _____ Hospital for supply of patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available for preparations of which are primarily food toilts or disinfectants.

Name of the Medicines	**Price (Rs.)**
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1.	

e). That the patient is/ was suffering from _____ and is / was under my treatment from _____ to _____.

f). That the X-ray, Laboratory Test etc. for which the expenditure of Rs._____ was incurred were necessary and were undertaken on my advice at the _____ hospital laboratory.

g). That I referred the patient to Dr._____ for special consultation and

h). That the patient did not require/ required hospitalization.

i) *Lab Reports : **Checked / Not Checked**

j) The Admissible amount for reimbursement: _____

Date_____

Signature & Designation of the Medical Officer
Regn. No.

N.B. : Certificate not applicable should be struck off certificate is compulsory and must be filled in by the Medical Officer in all cases
*Indicates mandatory