CERTIFICATE B

(To be completed in the case of patients who are admitted to hospital for treatment)

Certificate granted to Mrs/ Mr/ Miss……...
Wife/ son/ daughter of Mr/ Mrs……
Employed in the……

PART A

(To be signed by the Medical Officer in charge of……..case at the hospital)

I, Dr……..hereby certify-

a) That the patient was admitted at hospital on the advice of ……
…….
(name of the medical officer on my advice)

b) That the patient has been under treatment at…….and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious decoration in the condition of the patient. The medicines are not stocked in the…….
(name of the hospital) for supply to private patients and do not include proprietary preparations or which are primarily foods, toilets or disinfectants.

Name of the medicine (in block letters)	**Price**
1.	
2.	
3.	
4.	

c) that the injections administered were not for immunizing or prophylectic purpose

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

e) that the X/ray, laboratory test etc., for which an expenditure of Rs……..was incurred were necessary and were undertaken on my advice at…….
……
(name of the hospital or laboratory)

f) that I called on Dr……for specialist consultation and the necessary approval of the…….
(Name of the Chief Administrative Medical Officer of the state) as required under the rules, was obtained.

g) *Lab Reports : Checked/ Not Checked

* Indicates mandatory

Signature and Designation of the Medical Officer
In charge of the case at the hospital

PART B

I certify that the patient has been under treatment at the……hospital and that the service of the special nurse for which an expenditure of Rs……..was incurred, vide bills receipts attached, were essential for the recovery/ prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer
In charge of the case at hospital

COUNTER SIGNATURE OF THE MEDICAL SUPERINTENDENT OF THE HOSPITAL

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

Place: Medical Superintendent

Date: **……Hospital**

भारतीय प्रौद्योगिकी संस्थान गुवाहाटी
INDIAN INSTITUTE OF TECHNOLOGY GUWAHATI

FORM B

(Form of Application for Medical Claim)

(Hospital Indoor treatment)

1. a) Name and designation of the employee (in block letters) :

   b) Deptt/Section/ Centre/ Cell :
   i) Designation with Emp No./Roll No. :
   ii) Marital status :
   iii) If married, the place where the spouse is employed :

2. Pay of the Official ((In case of employee) :
3. Actual residential address :
4. Bank A/c no., IFSC, Bank name and branch :
5. Name of the patient and his/her relationship to the employee (In case of children specify age also) :
6. Place at which the patient fell ill :
7. Details of amount claimed :

   i) Name of the Hospital :
   ii) Charges for hospital treatment, indicating separately the charges for :

   a) Accommodation :

   b) Diet :

   c) Surgical operation or medical treatment or confinement :

   d) Pathological, bacteriological, radiological or similar tests :
   i) The name of the hospital or laboratory :
   ii) Whether undertaken on the advice of the medical officer, incharge of the hospital (Attach certificate) :

   * Indicates mandatory

e) Medicines/special medicines (cash memos/Essentiality Certificate to be attached) **(*Please submit Cash Memo / Bills in original only)** :

f) Special Nursing i.e. Nurses specially engaged for the patient (Attach a certificate of the Medical Officer In charge of the hospital)

g) Any other charges :

iii) Consultation with specialist (Certificate from Medical Officer to be attached) :

8. Fees for consultation, indicating :

Name & Designation Of the Medical Officer Consulted	**No. of consultation**	**Date of consultation**	**Fee paid**

(Cash memos and essentiality certificate should be attached)

9. Total amount claimed :

10. List of enclosure :

Signature of the Claimant

DECLARATION TO BE SIGNED BY THE EMPLOYEE/STUDENT

I hereby declare that the statements in the application are true to the best of my knowledge and behalf and the person for whom medical expenses were incurred is wholly dependent on me.

Dated.....

Signature of the Claimant

Contact no. ……

e- mail id(@iitg.ac.in)…….