

INDIAN INSTITUTE OF TECHNOLOGY, BHILAI
MEDICAL CLAIM FORM OPD TREATMENT

Application for claiming refund of medical expenses incurred in connection with medical attendance and treatment of Institute's Employees and their families.
 (Note: Separate Form should be used for each patient)

I. Status Information of the Claimant		
Claimant's Name	Designation	Department

Employee No.	Tel. No.	Email ID

II. Information regarding the patient				
Patient's Name & ID number	Relationship	Nature of illness	Name of Referring AMA	Treated Hospital Name

III. Please provide the following details of medical expenses.						
Sr. No	Particulars	Total Claim submitted	Total Amount Claimed (Office Use Only)	Sr.No.	Name of the Medicine OR Invoice No	Amount (Rs.)
1	MRI/CT scan/x-ray/Sonography/EGD			1		
2	Dialysis / ECG			2		
3	Appliance Purchased			3		
4	Laboratory Test/s Done			4		
5	No of Consultation Charges()			5		
6	Miscellaneous Charges			6		
7	Any Other			7		
8				8		
	Total				Total	
Total Claim Submitted :			Total Number of enclosures :			
Office Use Only						
Total amount claimed :						
Advance Taken :						

DECLARATION TO BE SIGNED BY EMPLOYEE

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:

Claimant Signature

Below Attachment are mandatory to process the Reimbursement. (Self-Attested documents)

1. Original bill receipt/s,
2. Copy of prescription/s.
3. IIT Bhilai Health Center referral.
4. If dependent Copy of dependent booklet

Countersigned and certified that the claim:

1. is genuine.
2. is covered by the rules and orders on the subject.
3. is supported by bills, receipt and other certificates etc.
4. was not drawn before and
5. has been sanctioned/countersigned by me.

Signature of Medical Officer
Health Center
IIT Bhilai
Seal

Faculty In-charge
Health Centre