INDIAN INSTITUTE OF TECHNOLOGY BHILAI

MEDICAL CLAIM FORM OPD

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. Information of the Claimant

Claimant's Name		Employee ID.	
Designation		Tel. No.	
Department		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 (in Rs)	Total Amount Recommended (in Rs) **(Office Use Only)**	Sr. No	Name of the Medicine OR Invoice No	Total Claim submitted (in Rs)	Total Amount Recommended (in Rs) **(Office Use Only)**
1.1	Imaging/MRI/CT Scan/x-ray/sonography			2.1			
1.2	CBC/Widal/LFT/RFT			2.2			
1.3	Urine-RM/Malaria			2.3			
1.4	TSH, T3, T4 Sr. Electrolytes			2.4			
1.5	Any other laboratory Test/s Done			2.5			
1.6	No of Consultation Charges( )			2.6			
1.7	Miscellaneous Charges			2.7			
1.8	Any Other.			2.8			
	Total (A)				**Total (B)**		
	Total Claim Submitted (A+B) :						
	Total Number of Enclosures :						
	Office Use Only						
	Advance Taken:						
	Total Amount Recommended:						

DECLARATION TO BE SIGNED BY EMPLOYEE

Below Attachment are mandatory to process the Reimbursement. (Self-Attested documents)
1. Original bill receipts 2. Copy of prescription 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 order of 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.

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

Total amount to be paid:

Register No.	
Serial No.	

Staff Nurse
Health Centre

Signature of the Medical Officer
Health Centre

Faculty In-Charge

Health Centre