

INDIAN INSTITUTE OF TECHNOLOGY BHILAI

To be filled by the students

Name of the Student/Patient		Age	
Id No.		Course/ Program	
Name of reference AMA		Contact No.	

A). Certified that I have taken treatment for the following:

Name of the illness/Diagnosis	
Duration of the Treatment*	From: To:

*This has to be claimed within one month of duration of treatment

B). Details of treatment and claim of reimbursement:

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 No. of Enclosures							
Office Use Only							
Advance Taken:							
Total Amount Recommended:							

C). Below Attachments are mandatory to process the reimbursement (Self Attested)

1. Referral letter by Medical officer of IIT Bhilai Health Centre.
2. Copy of prescriptions.
3. Original cash memos/receipts.
4. Copy of ID Card.

D). Bank Details:

Name and A/c No		IFSC Code	
Bank		Branch	

Date:

Place:

Signature of the Claimant

I Certify the above pathological tests prescribed by me to arrive at the correct diagnosis.

I also certify that patient has been under treatment as prescribed by me and above medicines are purchased due to non-availability at our health Centre.

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