**INDIAN INSTITUTE OF TECHNOLOGY**
**BHUBANESWAR – 751 013**

Application for Reimbursement of Medical Expenses incurred in connection with Medical Attendance and / or Treatment of Institute Employees and their Families

(**To be used for INDOOR TREATMENT at …………………………….. ………………………………..Hospital**)

N. B.: **Separate Form should be used for each Patient**

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**Employee Code** | **Name of employee (in block letters)** | **Designation**

**Deptt./Centre/School/Section** | **GP /AGP** | **Residential Address**

**Name of the Patient & Relation to the employee** | **Place at which the patient fell ill**

**Nature of illness & its duration**

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**DETAILS OF THE AMOUNT CLAIMED**

| | | |
|---|---|---|
| i) | Accommodation Charges | Rs. |
| ii) | Operation Charges | Rs |
| iii) | Pathological, Bacteriological or other similar Charges (Details with MO's advice and Cash Memos in original to be enclosed) | Rs |
| iv) | Cost of Medicines (List of medicines, Cash memos and essentiality certificates to be attached) | Rs |
| v) | Amount Claimed<br>a) Gross claimed<br>b) less advance taken, if any.<br>c) Net Claimed | <br>Rs.<br>Rs.<br>Rs. |

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**DECLARATION TO BE SIGNED BY THE MEMBER OF THE STAFF**

I hereby declare that :

(i) the claim is genuine;
(ii) the statements made in this application are true to be best of my knowledge and belief;
(iii) the person for whom the medical expenses were incurred is wholly dependent upon me and is not an earning member of the family;
(iv) my wife/husband is not employed and the reimbursement has not been claimed form her / his source of employment;
(v) the claim was not drawn before me.

**Date : …………………………………..** **Signature of the Employee**

## ESSENTIAL CERTIFICATE

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

**P A R T – A**

(to be signed by the Medical Officer-in-Charge of the case at the Hospital)

I, Dr. ………………………………………………………………………………………………………….… hereby certify

a) that the patient was admitted to hospital on the advice of Dr. ……………………………………..……. .(name of the Medical Officer) / on my advice;

b) that the patient has been under treatment at the ……………….…………….……..Hospital 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 to private patients and do not include proprietary, preparations for which cheaper substances of equal therapeutic value are available for preparations which are primarily food toilets or disinfectants;

| | Name of medicine | Quantity | Price (Rs.) | | Name of medicine | Quantity | Price (Rs.) |
|---|---|---|---|---|---|---|---|
| 1 | | | | 5 | | | |
| 2 | | | | 6 | | | |
| 3 | | | | 7 | | | |
| 4 | | | | **Total Rs.** | | | |
| NB:- Attach a separate sheet if needed. | | | | | | | |

c) that the injections administered were not for immunizing or prophylactic purposes;

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

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

f) that I called in Dr. ……………………………………………………………………………for specialist consultation.

g) All the bills have been verified and signed by me.

**Seal & Signature of the Medical Officer in Charge**

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**P A R T – B**

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

***Signature of the M. O –in-Charge of the case***

**COUNTERSIGNED**

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

Place : ……………………………………….

Date : …………………………………………

Medical Superintendent : …………………………………………

Hospital : ……………………………………………………………

**(FOR OFFICE USE ONLY)**

Bill No. …………………………………………… Date…………………
Gross Payable Rs. ………………………………………..
Less: Advance Rs. ………………………………………..
(Bill No.: …………………………………………… Date ……..………… )
Net payable Rs. ………………………..……..
Passed for Payment for Rs. ……………………………..…..
(Rupees ……………………………………………………………..………)
As per the above claim which is covered by Rules and was not drawn before

***Accountant*** ***Asstt. Registrar (A/cs.)***

**AUDIT ENFACEMENT**
Checked and admitted for Rs. ………..………..

Auditor ……………………………….……………..
Audit Officer ……………………………….………..

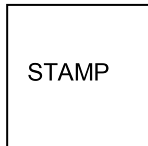
**COUNTERSIGNED**

***Registrar***

Pay Rs. ……………… (Rupees ……………………………………….……………………………………………..only)

Received the above payment vide voucher No……………………………………..

Date:………..……….



STAMP

**Cashier**

**Registrar / AR (F & A)**
**(Disbursing Officer)**