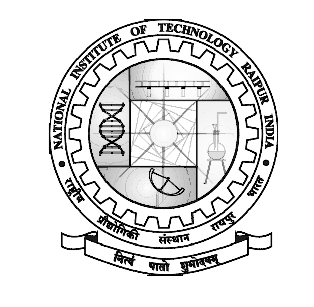
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**NATIONAL INSTITUE OF TECHNOLOGY RAIPUR**

**(Institute of National Importance)**

** G.E. Road, Raipur – 492010 (C.G.)**

# APPLICATION REPORT FOR MEDICAL REIMBURSEMENT (OPD & ADMITTED PATIENT)

|  |  |  |
| --- | --- | --- |
| **1.** **Name:** | **Designation:** |  |
| **2.** **Department:** | **Basic & Pay Level:** | **&** |
| **3 Actual Residential Address:** | | |
| **4.** **Name** **of** **the** **patient:** |  | **Contact** **No.:** |
| **5. His/her relationship with Government Servant:** | | |
| 1. **In the case of children state :**    1. **Date of birth:** | | |
| **(ii) Serial number in order of birth:** | | |
| **(iii) Total number of children:** | | |

**Treatment Taken (As OPD Patient)**

|  |  |  |  |
| --- | --- | --- | --- |
| Heading | OPD Treatment 1 | OPD Treatment 2 | OPD Treatment 3 |
| Name of illness: |  |  |  |
| Duration of illness: |  |  |  |
| Place at which patient fell ill: |  |  |  |
| Doctor/Hospital Name |  |  |  |
| Hospital Authorization: |  |  |  |
| The number & dates of consultation: |  |  |  |
| Consultation fee paid: |  |  |  |
| Charges for pathological, bacterio, logical radiological or other similar tests under taken during diagnosis indicating: |  |  |  |
| The name of hospital or laboratory were the test undertaken: |  |  |  |
| Where the tests were undertaken on the advice of the authorized medical attendant if so, certificate to that effect should be attached: |  |  |  |
| Cost of medicines purchased from the market (List of medicines cash memo and the essentiality certificate should be attached): |  |  |  |
| Any other charges: |  |  |  |
| Justification for other charges: |  |  |  |

* Whether hospital is authorized by Central Government/ State Government/ CGHS Rules/ CS (MA) rule/ Institute empanelled hospital/ any other hospital/ clinic\*. (Please mention appropriate one and also attach the supportive Documents )
* In case of treatment taken from any other hospital/clinic, please attach a proper justification for the same.

**PARTICULARS** **OF** **AMOUNT** **CLAIMED AS OPD PATIENT**

|  |
| --- |
| **For OPD Treatment 1** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S.N.** | **Hospital** **Name/Medical** **Shop/Pathology** **Lab/Consultant** | **Bill** **No.** **and** **Date** | **Amount** **Claimed** | **For** **office** **use** **only** | |
| **Admissible**  **amount** | **Remarks** **of** **Medical**  **Officer** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **Total** **Amount 🡪** | | | | **🡨 Admissible** **Amount** | |

|  |
| --- |
| For OPD Treatment 2 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S.N.** | **Hospital** **Name/Medical** **Shop/Pathology** **Lab/Consultant** | **Bill** **No.** **and** **Date** | **Amount** **Claimed** | **For** **office** **use** **only** | |
| **Admissible**  **amount** | **Remarks** **of** **Medical**  **Officer** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **Total** **Amount 🡪** | | | | **🡨Admissible** **Amount** | |

|  |
| --- |
| For OPD Treatment 3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S.N.** | **Hospital** **Name/Medical** **Shop/Pathology** **Lab/Consultant** | **Bill** **No.** **and** **Date** | **Amount** **Claimed** | **For** **office** **use** **only** | |
| **Admissible**  **amount** | **Remarks** **of** **Medical**  **Officer** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **Total** **Amount 🡪** | | | | **🡨 Admissible** **Amount** | |

|  |  |  |  |
| --- | --- | --- | --- |
| Overall Total OPD Claim Amount  (OPD Treatment 1+2+3) |  | Overall Total OPD Admissible Amount( OPD Treatment 1+2+3) |  |

**Treatment Taken** **(As** **Admitted** **Patient)**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.N.** | **Doctor/Hospital Name** | **Name of Illness** | **Dates** |
|  |  |  |  |

**Hospital treatment (As Admitted Patient)**

A Charges for hospital treatment including separately the charges for- ..…………………………………………………………………..

(i) Accommodation state whether it was according to the states or pay

of the Government Servant & in cases where the accommodation ……………………………………………………………………….

in the higher than the status of the Government servant a Certificate

should be attached to the effect that accommodation to which he was

entitled was not available.

(ii) Dist. ……………………………………………………………………………….

(iii) Surgical operation or Medical treat- ……………………………………………………………………………….

(iv) Pathological bacteriological or other similar tests indicating ……………………………………………………………………………….

1. The name of hospital or laboratory at which

Undertaken and ……………………………………………………………………………….

b) Whether undertaken on the advice of the medical

Officer In- charge of the case at the hospital if so a ……………………………………………………………………………….

Certificate to that effect should be attached.

(v) Medicines ……………………………………………………………………………….

(vi) Special Medicines

(List of medicines cash memos & the essentiality certificate ……………………………………………………………………………….

Should be attached)

(vii) Special nursing i.e. nurses specially engaged for the Patient- State

whether they were employed on the advice of the medical officer

in- charge of the case at the hospital or at the request of the Gove-

rment servant or patient in the former case a certificate from the ….……………………………………………………………………...

M.O.I.C. Superintendent of the hospital should be attached.

(viii) Any other charges e.g. charges for electric light fan, heater, air-

conditioning, etc. State also what are the facilities referred to are a

part of facilities normally provided to all Patients and no choice was ………………………………………………………………………….

left to patient.

B. PARTICULARS OF AMOUNT CLAIMED AS ADMITTED PATIENT

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S. N.** | **Hospital Name/Medical Shop/Pathology**  **Lab/Consultant** | **Bill No. and Date** | **Amount**  **Claimed** | **For office use only** | |
| **Admissible**  **amount** | **Remarks of Medical**  **Officer** |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| **Requested** **Total** **Amount:** | | | | **Admissible** **Total** **Amount** | |

|  |  |  |  |
| --- | --- | --- | --- |
| Overall Total Admitted  Claim Amount |  | Overall Total Admitted Admissible Amount |  |

**Note:** **If** **treatment** **was** **received** **by** **the** **Government** **servant** **at** **his** **residence** **give** **particulars** **of** **such** **treatment** **and** **attached** **certificate** **from** **authorized** **Medical** **attendant.**

|  |  |  |  |
| --- | --- | --- | --- |
| OVERALL TOTAL  CLAIM AMOUNT  (OPD + ADMITTED) |  | OVERALL TOTAL ADMISSIBLE AMOUNT  (OPD + ADMITTED) |  |

|  |  |  |
| --- | --- | --- |
| **List** **of** **enclosures.** | **Sr. No.** | **ENCLOSURE** **NAME** |
| 1 |  |
|  | 2 |  |
|  | 3 |  |
|  | 4 |  |
|  | 5 |  |

**UNDERTAKING**

1. **I ...............................am a regular Employee/Officer of NIT Raipur. I hereby declare that I am entitled for Medical Reimbursement claim from the Institution for self & my dependent family members. I also declare that any kind of excess payment given to me against the Medical Reimbursement claim may be recovered according to the norms of the Institution.**

1. **I** **also** **declare** **that** **Shri/Smt./Master ……………………………** **aged ………** **years** **for** **whom** **the** **Medical** **treatment** **was** **taken** **is** **my…………………………………** **and** **is** **fully** **depended** **upon** **me** **&** **his/her** **name** **is** **also** **entered** **in** **my** **service** **book.** **My** **family** **members** **who** **are** **availing** **medical** **reimbursement** **facility** **are** **wholly** **dependent** **on** **me.** **The** **income** **of** **dependent** **family** **members (other** **than** **spouse) does** **not** **exceed** **the** **amount** **of** **minimum** **pension** **prescribed** **in** **central** **government (i.e.** **Rs** **9000 P.M.)** **and** **dearness** **relief** **thereon. I** **also** **declare** **that** **I** **have** **applied** **this** **Medical** **Reimbursement** **claim** **only** **at** **NIT** **Raipur.**
2. **I also declare that treatment taken from…………………………………………(name of hospital) is authorized by Central Government/ State Government/CGHS Rules/ CS (MA) Rule/ Institute empanelled hospital / any other hospital/ Clinic ……………………………………………………..(please tick appropriate one and also attach the supportive documents).**

* **In case of treatment taken from any other hospital/clinic, please attach a proper justification for the same.**

I hereby declare that the statements in application are true to the best of my knowledge**.**

Important Note:

1. **Age** **of** **children:-For** **availing** **medical** **reimbursement:**
   1. **The** **age** **of** **unmarried** **son** **for** **availing** **medical** **reimbursement** **facility** **will** **be** **considered** **till** **he** **starts** **earning** **or** **attain** **the** **age** **of** **25** **years** **whichever** **is** **earlier.**
   2. **The** **age** **of** **daughter** **for** **availing** **medical** **reimbursement** **facility** **will** **be** **considered** **till** **she** **starts** **earning** **or** **gets** **married,** **whichever** **is** **earlier,** **irrespective** **of** **age** **limit.**
2. All other terms and condition are as per prevailing service rules.
3. I hereby declare that the statements in application are true to the best of my knowledge.

**Signature of Employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sr. No.** | **Hospital/Doctor Name**  **(Empanelled List AML)** | **Treatment taken as**  **OPD/Admitted** | **Authorized** **by** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use only

It is verified from office record that Shri/Smt. ………………………………………… is a regular employee of NIT Raipur and patient ……………………………………………. is dependent of him/her.

Medical Officer Joint Registrar

Verified Payment of Rs.………………………………..may be approved.

Dean (FW)

Medical Officer