भारतीय सूचना प्रौद्योगिकी संस्थान, नागपुर

FORM OF APPLICATION FOR MEDICAL REIMBURSEMENT (OPD)

1	Name and designation of Government Servant	_____
2	Department/Section in which employed	_____
3	Basic & Level in Pay Matrix	_____
4	Actual residential Address.	_____
5	Name of the patient and his/her relationship with Government Servant.	_____
6	In the case of children:	_____
	(i)Date of birth	_____
	(ii)Serial Number in order of birth	_____
	(iii)Total number of children	_____
7	Place at which patient fell ill	_____
8	Name of illness and duration	_____
9	Name of Hospital where treatment taken	_____
10	Whether Hospital / Lab is NABH empanelled.	**Yes/No**
11	Total amount claimed.	**₹_____ /- (As per Certificate "A")**

UNDERTAKING

1. I (name) _____, a regular employee of IIIT, Nagpur, hereby declare that I am entitled for Medical Reimbursement claim from the Institution for self & my dependent family members under CGHS rates. I also declare that any kind of excess payment made as reimbursement may be recovered according to the norms of the Institution.
2. I also declare that Shri/Smt./Master/Ms_____ aged _____years for whom the medical treatment was taken is my _____(relationship) and his/her name is included as dependent in office records. I also certify that this Medical Reimbursement claim is made only at IIIT, Nagpur.
3. I also declare that treatment taken from _____ (name of hospital) is Institute empanelled Hospital/Clinic.

I have attached all supporting documents (Consultation Fee, Prescription, Medicine Bill, X-Ray/Lab Test Bill, etc.) duly signed by the Doctor/Hospital and have requested for reimbursement as per the CGHS prescribed rate only. I also hereby declare that the statements made above are true to the best of my knowledge & belief.

Date:_____

Signature of Employee _____
(Name & Designation)

For Office Use only

1. It is verified from available office records that the claimant is a regular employee of IIIT, Nagpur and patient _____is dependent of him/her.
2. The claim has been duly verified and the essentiality of the lab tests/ medicines/ injections etc. administered during treatment is certified. The claim has been regulated as per CGHS rates/Govt. of India orders, as applicable from time to time.

R.M.O (IIITN) **AOSD** **Asst. Registrar (A/c)**

Approved / Not Approved

I/c Registrar

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CERTIFICATE-A

(To be completed in the case of patients who are not admitted to hospital for treatment)

Certificate granted to **Mrs./Mr./Miss** _____
wife/son/daughter/mother/ father of_____
employee of **Indian Institute of Information Technology, Nagpur.**

I, **Dr.** _____ of _____
(hospital name) is empaneled with IIIT, Nagpur has followed rules and have charged rates prescribed by CGHS hereby certify: -

(a) That I have charged and received ₹_____ for _____consultations on ____/____/_____ at my consulting room/at the residence of the patient;

(b) That I charged and received ₹ _____ for administering _____ intra-venous/intra-muscular/ sub- cutaneous injection on ____/____/_____ at my consulting room/the residence of the patient.

(c) That the injections administered were not/were for immunizing or prophylactic purposes;

(d) that the patient has been under treatment at _____ (hospital name) /my consulting room 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 name) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants;

Sr. No	Name of Medicines	Price in ₹	Sr. No	Name of Medicines	Price in ₹
1			6		
2			7		
3			8		
4			9		
5			10		
				TOTAL	

(e) That the patient is/was suffering from_____
and is/was under treatment from ____/____/_____to ____/____/_____;

(f) That the patient is/was not given pre-natal or post-natal treatment;

(g) That the X-ray, laboratory tests, etc., for which an expenditure of ₹_____ was incurred were necessary and were under taken on my advice at _____
_____ (name of hospital or laboratory);

(h) Total Expenditure Incurred (inclusive of Consultation Charges, injection charges, X-Rays/ Lab test Charges & Medicine Bill) is ₹_____in **Rupees (word**s) _____**;**

(i) that the patient did not required/required hospitalization.

Attachments: -

1. Medicine Bills with prescription
2. X-Ray/ Lab test bills with prescription
3.
4.

Name & Signature with Stamp of the Medical Officer in-charge of the Hospital