**jk"Vªh; izkS|ksfxdh laLFkku & jk;iqj**

**NATIONAL INSTITUE OF TECHNOLOGY RAIPUR**

**(Institute of National Importance)**

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

****

**Form-I**

**FORM OF APPLICATION FOR MEDICAL REIMBURSEMENT**

**(See Rule [8] I)**

**(N.B. – SEPARATE FORM SHOULD BE USED FOR EACH PATIENT)**

1. Name and designation of government \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Servant in block letters

1. Department/Section in which employed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Basic & Grade Pay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Actual residential Address. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Name of the patient and his/her relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

with Government Servant. In the case of children state :

(i) Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ii) Serial Number in order of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(iii) Total number of children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Place at which patient fell ill \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of illness and duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Name of Dr./Hospital where treatment taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Whether hospital is authorised 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*

1. Treatment taken as : OPD Patient/Admitted patient
2. Details of the amount claimed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A** - **Treatment** (**As OPD Patient)** :-

(i) (a) Fees of consultation paid - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(b) The number and dates of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consultation. (Pl. attach receipt)

(ii) Charge for pathological, bacterio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

logical, radiological or other similar tests under taken during diagnosis indicating.

(a) The name of the hospital or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ laboratory were the test

 undertaken and.

(b) Where the tests were undertaken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 on the advice of the authorised

 medical attendant and if so, certificate

 to that effect should be attached.

(iii) Cost of medicines purchased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

from the market (List of medicines,

Cash memo and the essentiality certificate should be attached)

**B**- **Hospital treatment**  **(As Admitted Patient)**–

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-

(a) The name of the 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 Government

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.

 Note – If treatment was received by the Government

servant at his residence give particulars of such

treatment and attached certificate from

authorised Medical attendant.

1. Total amount claimed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List of enclosures. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Particulars of Amount claimed**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.N.** | **Name of Medical Shop/ Pathology Lab/Consultation Fee** | **Bill No. and Date** | **Amount Claimed** | **For Office use only** |
| **Admissible amount** | **Remarks of Medical Officer (if any)** |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 |  |  |  |  |  |
| 13 |  |  |  |  |  |
| 14 |  |  |  |  |  |
| 15 |  |  |  |  |  |
|  | **TOTAL :** |  |  |  |  |

**UNDERTAKING**

1. I (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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 Medical Reimbursement claim, may be recovered according to the norms of the Institution.
2. I also declare that Shri/Smt./Master\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ aged \_\_\_\_\_\_\_\_\_years for whom the Medical treatment was taken is my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(relationship) and is fully depended upon me & his/her name is also entered in my service book. I also declare that I have applied this Medical Reimbursement claim only at NIT Raipur.
3. I also declare that treatment taken from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of hospital) is authorised 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.

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

**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.

 ***Dy. Registrar (Admin)***

***Sr. Medical Officer***

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

***Sr. Medical Officer***

***Dean (FW)***