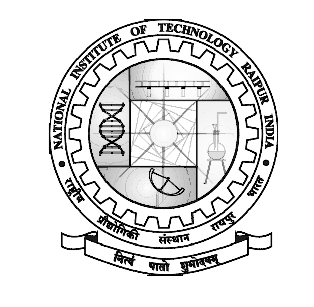
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**NATIONAL INSTITUE OF TECHNOLOGY RAIPUR**

**(Institute of National Importance)**

**G.E. Road, Raipur – 492010 (C.G.)**

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**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 |  |  |  |  |  |
|  | **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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile No.** …………………………………………………

**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.

**Joint Registrar**

**Medical Officer**

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

**Dean (FW) Medical Officer**