राष्ट्रीय प्रौद्योगिकी संस्थान रायपुर
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:**	
6.	**In the case of children state :**	
	(i) 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** .....

a) 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.**

2. **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.**

3. **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:**

A. 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.

B. 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**