



भारतीय प्रौद्योगिकी संस्थान भुवनेश्वर
INDIAN INSTITUTE OF TECHNOLOGY BHUBANESWAR

INDOOR CLAIM FORM

Application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment of institute employees and their dependant family members.

[Separate form should be used for each patient.]

Employee Details

Name: _____ (Employee Code.) _____

Designation: _____

Department / Centre / School/ Section: _____

Basic Pay: _____

Contact No.: _____

Patient Details

Name: _____

Age: _____

Relationship to the Employee: _____

DETAILS OF THE AMOUNT CLAIMED

a)	Accommodation Charges	Rs.
b)	Fees for Operation/Consultation	Rs.
c)	Charges for pathological, bacteriological, radiological or other similar tests undertaken as per the advice of the treating doctor	Rs.
d)	Cost of medicines purchased from the market.	Rs.
e)	Any other charges	Rs.
f)	Advance drawn, if any	Rs.
	Total amount claimed (a+b+c+d+e - f) (In Words: _____)	Rs.

Attachments

1. Self-certified Prescription copy for the above a, b, c,d,e categories, as applicable.
2. Self-Certified Original Cash Memo/ Receipt towards the above a, b, c, d, e categories, as applicable.
3. Discharge Certificate
4. Essential Certificate from treating doctor (as per attached format).

I hereby certify that the patient, for which the claim is made, is myself/a dependent member of my family. I also certify that the claim is genuine and this bill has not been claimed before.

Signature of Employee with Date



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INDOOR CLAIM FORM

<u>TO BE USED IN THE SANJEEVAN HEALTH CENTRE</u>	(Receiving date stamp)
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Amount Claimed: Rs. _____

Amount Deducted: Rs. _____

(Reason _____)

Net Amount Payable: Rs. _____

(in Words): Rupees.....only)

Dependency verified. The prescription and the cash memo(s)/Receipt(s) are found to be in order.

Signature with Date
(Dealing assistant)

Countersigned and certified that the claim **i)** is covered by the rules and orders on the subject, and **ii)** has been recommended.

Additional Remarks (if any): _____

Signature with Date
(MO)

Signature with Date
(SMO/CMO/PIC)

<u>TO BE USED IN THE ACCOUNTS DEPARTMENT</u>	(Receiving date stamp)
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Passed for payment for Rs. _____ (in Words: Rupees)

.....

only)

Countersigned and certified that:

- The claim is supported by bills, receipts and other certificates, etc.
- The advance drawn by the claimant is _____, which has been duly considered in the claim.

Signature with Date
ACCOUNTANT

ESSENTIAL CERTIFICATE

(To be completed in the case of patients who are admitted to a hospital for treatment)

I, Dr. hereby certify that

- a) the patient was admitted to the hospital on my advice, and
- b) the patient has been under treatment at Hospital and that the medicines prescribed by me (as per my prescription) in this connection were essential for the recovery / prevention of serious deterioration in the condition of the patient.

Seal & Signature with Date
(Treating Doctor)
