आत्मा राम सनातन धर्म महाविद्यालय
ATMA RAM SANATAN DHARMA COLLEGE
(दिल्ली विश्वविद्यालय) /(UNIVERSITY OF DELHI)
धौला कुआँ, नई दिल्ली-110021 / DHAULA KUAN, NEW DELHI - 110021

MEDICAL REIMBURSEMENT CLAIM FORM

N.B. Separate form should be used for each patient

1. Name, Designation and Department of the employee :
   (in BLOCK letters)
   (i) Whether married or unmarried :
   (ii) If married, the place where spouse is employed (if applicable)
   (In case employed, a Joint declaration duly countersigned by the wife/husband's employer may be furnished at the time of first bill in each financial year).
2. Basic Pay / Basic Pension of the Applicant :
3. Actual residential address and mobile no. :
4. Name of the patient and his/her relationship with the employee.
   N.B. in the case of children state age also
5. Place at which the patient fell ill :
6. W.U.S. Health Center Membership No. :
7. TREATMENT FOR WHICH REIMBURSEMENT CLAIMED: (TICK□ ANY ONE)

A) OPD treatment/ Tests and investigations
b) Indoor Treatment

8. Patient suffering from (specify disease) : .....

   Period of treatment from..... to.....
9. Details of the amount claimed :

A) MEDICAL ATTENDANCE

(i) **Fees for consultation, including :**

(a) The name, qualification and designation of the medical officer consulted and the hospital or dispensary to which attached.....

(b) The number and dates of consultations and the fee paid for each consultation.....

.....

(ii) **Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating.**

(a) The name of the hospital or laboratory where the tests were undertaken.....

.....

(b) Whether the tests were undertaken on the advice of the authorised medical attendant. (Attach certificate to that effect) and charges.

(iii) Cost of medicines purchased from the market.

(iv) Others .....

Note : List of medicines, cash memos and the essential certificates should be attached.

B) INDOOR TREATMENT (HOSPITALIZATION)

(i) Name of Hospital.....

(ii) Accommodation charges.....

(iii) Medical treatment eg. surgical operation etc. .....

contd. P/2

(iv) Test charges .....

(v) Cost of Medicines .....

(vi) Others .....

10. Total amount Claimed : Rs .....

11. List of enclosures :

1. ..... Nos.....
2. ..... Nos.....
3. ..... Nos.....
4. ..... Nos.....
5. ..... Nos.....
6. ..... Nos.....

Total = Nos.....

12. Bank Account Details

Name of A/c. Holder	Bank Name	Account No.	IFS Code

DECLARATION TO BE SIGNED BY THE CLAIMANT

I hereby declare that statements in this application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent upon me.

(PRE-RECEIPTED)

Date .....

Signature of the Claimant

(FOR OFFICE USE ONLY)

Bill has been entered in the Medical Register at Page No. .....

Debitable to Medical Expenses (PFMS Code : B.36.02)

Paid vide Cheque no./NEFT Ref. no./P.P.A. no..... Date.....

for the sum of Rs. ..... (Rupees .....

.....)

Dealing Asstt. S.O. (A/cs) A.O. Bursar Principal Chairman/Treasurer

UNDERTAKING

If as a result of further checking by the College/University/U.G.C. or Auditors, if it is found later that some excess payment has been made to me on account of this medical bill, I under-take the responsibility of refunding the same or of authorizing the Principal to deduct the excess payment made to me from my salary/ pension.

(Signature of the Claimant)