



# INDIAN INSTITUTE OF TECHNOLOGY INDORE

## CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES

Name of the Applicant		Designation & Department	
Grade Pay		Mobile No.	
Name of Patient		Relationship with employee	

### PROFESSIONAL, DIAGNOSTIC & MEDICINE EXPENSES

Nature of Expenditure	Prescription / Reference by (Name of the Doctor)	Name of the Lab / Hospital	Medicines purchased from (Name of the Shop)	Bill No.	Date	Amount (Rs.)
1. Specialist Consultation						
2. Lab. Test						
3. IPD Charges						
4. Room Charges (Excl./Incl. diet charges)						
5. Any other charges (i)						
(ii)						
(iii)						
(iv)						
<b>Total Amount (Rs)</b>						

### EMPLOYEES'S DECLARATION

I certify that the details given above are true and that person, for whom the above medical expenses are incurred, is wholly dependent on me and this claim was not drawn before.

Total amount claimed (Rs)		Advance taken, if any (Rs)		No. of bills enclosed	
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Date: \_\_\_\_\_ Signature of the Applicant

### FOR Health Centre Use

Scrutinized and Checked.

Date: \_\_\_\_\_ Signature of Medical Officer

**(FOR FINANCE OFFICE USE)**

Amount Claimed Rs \_\_\_\_\_

Amount passed for payment of Rs \_\_\_\_\_

**Dy. Manager**

**Manager**

**AR/DR**

**Registrar**

**For Bank Detail (only for B. Tech students)**

**Bank Name:**\_\_\_\_\_.

**Account No.:** \_\_\_\_\_.

**Account Name:**\_\_\_\_\_.

**IFSC :**\_\_\_\_\_.

**Note:**

1. The certificate is to be signed only by the Superintendent of the Hospital / Doctor of the Institute or any other doctor authorized by the Institute for this purpose only.
2. Only the cost of medicines not included in the list of inadmissible medicines as prescribed by the Government of India from time to time would be reimbursed by the Institute.
3. Medical expenses incurred by the members or their families in Govt. Hospital / Private Clinic Hospital outside Indore are also reimbursable subject to the certificate given by the IITI doctors and reimbursement will be restricted as per CGHS rates.
4. Medical expenses incurred under the Ayurvedic / Homeopathic Systems are reimbursable, only if treatment is obtained from registered medical practitioner in their system of medicine. A valid prescription and details of treatment are essential. A certificate from the treating doctor in the format given below has to be attached with reimbursement form.
5. Diet charges for a patient admitted to hospital are not reimbursed.
6. As per CS (MA) Rules, medical bills must be submitted **within 3 months** from the date of cash memo / other bills.
7. Each page of prescription should have name and other details of the patient and must have signature, seal and the registration number of treating doctor.
8. Prescriptions (not older than one month) must be attached for each invoice. This is also applies to pediatric vaccination charges.
9. The consultation of allied services taken directly is not reimbursement.
10. Physiotherapy / occupational services will be limited as per CGHS rates. The details of exercise and charges should be listed along with prescription / advised of orthopedic/ neurologist or other treating specialist.
11. The prescriptions for reimbursement should be in English/Hindi for Ayurvedic/Homeopathic.
12. For Dental treatment, details of treatment, area involved of X-ray taken per day should be attached.
13. For reimbursement of indoor treatment / admitted patient, prescription of each invoice must be attached. A certificate from the treating doctor in the format given below has to be attached with the reimbursement form.
14. For chronic illness, such as hypertension, diabetes prescription maximum up to 3 months old can be considered.

**LIST OF DOCUMENTS TO BE SUBMITTED (Duly signed by the employee)**

1. Copy of prescription with diagnosis, discharge summary.
2. The prescription should have name of patient, his details, name and registration number of the Doctor with his system of medicine. On multiple papers, the name of patient and signature and seal of treating doctor on each prescription is necessary.
3. Copy of prescription with original pharmacy bills.
4. Prescription for investigation and evaluation by allied services
5. If the prescriptions given back of next blank page, patients name other details and doctor's seal required.
6. Other relevant reports.



# Indian Institute of Technology, Indore

Khandwa Road, Simrol, Indore - 453552

## HEALTH CENTRE

**CERTIFICATE FROM THE TREATING HOSPITAL / DOCTOR**

**(For Indoor/Admitted Patients, Ayurveda and Homeopathy) Treatment**

Certified that Shri/Smt.....Son/daughter/wife of

Shri/Smt.....of Indian Institute of Technology, Indore was

under my treatment (diagnosis) as an Indoor/outdoor patient at .....Hospital.

Period of Hospitalization/OPD: From.....To.....

All the bills / cash memos have been signed by me

Signature & Name of Designation of treating Physician / Surgeon

Please put your Stamp in this space.

(Counter Signature

& Stamp of Medical Superintendent of the Treating Hospital)

**For admitted Patients, attached photocopies of discharge sheet & other relevant documents with original detail bills**