SRI VENKATESWARA COLLEGE

(University of Delhi)
Benito Juarez Road, Dhaula Kuan, New Delhi- 110 021

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)			
Name			
Designation			
Department			
(i) Whether married or unmarried: ✓ ☒			
MARRIED		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 and Pay Level / Basic Pension of the employee:		**Basic Pay (Rs.)**	
		Pay Level:	
		Basic Pension (Rs.)	
3. (i) Current residential address :-			
(ii) Mobile No. :-	**(iii) Email ID: -**		
4. Name of the patient and their 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 Card No. :			
7. Treatment for which reimbursement claimed: (Yes /No) a) OPD treatment! Tests and investigations b) Indoor Treatment			
8. Patient suffering **from**……Period of treatment From……to……			
9. Details of the amount claimed in Rupees :			

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) Number of consultations (In Number) ……

(c) fee paid for each consultation (Rs.) ……

(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 (Rs.) ……

(iv) Others (Rs.)…………

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

B) INDOOR TREATMENT (HOSPITALIZATION)

(i) Name of Hospital ……

(ii) Accommodation charges (Rs.)……

(iii) Medical treatment e.g. surgical operation etc. ……

(iv)Test charges (**Rs.)** ……

(v) Cost of Medicines (Rs.) …………

(vi) Others (Rs.)……

10. Total amount Claimed: (Rs) ……

Name of the Medicines (IN BLO CK LETTER)	**Name of the Tests**

Please use separate sheet(s), if required.

11. Details of enclosures (Medical prescription, Medical bills, Medical (Test/s) report/s etc must be signed by the claimant. The same shall be attached with the Medical Reimbursement Claim Form for necessary verification).

PART 'B'

(Part 'B' certificate must be signed in case of hospitalisation)

I certify that the patient has been under treatment at the _____ hospital and the service of the special nurses for which an expenditure of Rupees _____ was incurred, vide bills & receipts attached were essential for the recovery/ prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer/ In-Charge of the case at the hospital
(With Official Stamp)

COUNTERSIGNED

Medical Superintendent

_____Hospital

I certify that the patient has been under treatment at the _____

_____ hospital and that the facilities provided were the minimum which were essential for the patient's treatment.

Medical Superintendent

_____ Hospital

Note: Certificate not applicable should be struck off.
Certificate(s) is compulsory and must be filled in by the Medical Officer in all cases.

DECLARATION BY THE CLAIMANT FOR CLAIMING REFUND OF MEDICAL EXPENSES

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

I further undertake that I shall be liable to any disciplinary / legal action initiated by the college in case anything is found to be forged/unauthentic/fake.

Note: "Husband/ wife/ child/ parent having an independent source of income is not related as member belonging to the family of the Government Servant except when the income including pension but excluding dearness relief on pension or stipend etc. less than Rs. 9000/- per month, as per existing rules".

UNDERTAKING BY THE CLAIMANT

As a result of further verification by the college/university/UGC or Auditors, if it is later discovered that some excess payment has been made to me on account of the medical bill(s), I undertake the responsibility of refunding the same or of authorizing the Principal/competent authorities to deduct the excess payment made to me from my salary/pension.

Note: - It may be noted that non-submission of necessary particulars in the prescribed form and document(s) shall lead to unnecessary delays in payment, if otherwise eligible. Utmost care may kindly be taken for the needful.

Signature of the claimant with date

(FOR OFFICE USE ONLY)

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

Debatable to Medical Expenses (PFMS Code : B.36.02) Paid vide Cheque no./ NEFT Ref. no./ P.PA No.

…….. Date …… for the sum of Rs. ……..

(Rupees ……..)

Dealing Assistant **S.O. (Accounts)** **A.O.** **Bursar** **Principal**