**INDIAN INSTITUTE OF TECHNOLOGY INDORE**

**Form: F12**

**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**
 |  |  |  |  |  |  |  |  |
| 1. **Lab. Test**
 |  |  |  |  |  |  |  |  |
| 1. **IPD Charges**
 |  |  |  |  |  |  |  |  |
| 1. **Room Charges (Excl./Incl. diet charges)**
 |  |  |  |  |  |  |  |  |
| 1. **Any other charges** (i)
 |  |  |  |  |  |  |  |  |
|  (ii) |  |  |  |  |  |  |  |  |
|  (iii) |  |  |  |  |  |  |  |  |
|  (iv) |  |  |  |  |  |  |  |  |
| **Total Amount (Rs)** |  |

**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 |   |
| 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 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.



(Counter Signature

& Stamp of Medical Superintendent of the Treating Hospital)

Signature & Name of Designation of treating Physician / Surgeon

Please put your Stamp in this space.

All the bills / cash memos have been signed by me

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

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.

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

**CERTIFICATE FROM THE TREATING HOSPITAL / DOCTOR**

**HEALTH CENTRE**

**Khandwa Road, Simrol, Indore - 453552**

**Indian Institute of Technology, Indore**

**For admitted Patients, attached photocopies of discharge sheet & other relevant**

**documents with original detail bills**