ABV-INDIAN INSTITUTE OF INFORMATION TECHNOLOGY AND MANAGEMENT (ABV-IIITM), GWALIOR (MP)

MEDICAL REIMBURSEMENT APPLICATION FORM

P.F. No./Roll No.....

- 1. Name, Designation, Department:
- 2. Pay Scale as defined in fundamental Rules: Rs.
- 3. Actual residential address:
- 4. Name of the patient and his/her relationship to the employee (in the case of children state age also) and the place patient fell ill.
- 5. Details of the claimed:
 - i) Medical Attendance:
 - a) Name and designation of the Medical Adviser:
 - b) Number and dates of consultation and fee paid for each consultation injection.
 - ii) Consultation with Specialist:
 - a) Name and designation of the Specialist
 - b) Number and dates of consultation and fee paid for each consultation.

iii) Charges for pathological bacteriological tests:

- a) Name of hospital Lab where undertaken.
- b) Whether undertaken on the advice of Medical Adviser/Medical Officer.

iv) Cost of Medicines Cash memo(s) to be attached:

6.Total amount claimedRs._____7.Less advance takenRs._____8.Net amount claimedRs._____9.List of enclosures: (i)(ii)

DECLARATION

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

- 1. Certified that my FATHER is not an earning member. He is wholly DEPENDENT upon me and is residing with me.
- 2. Certified that my FATHER is not an earning member and my MOTHER is WHOLLY DEPENDENT upon me. She is also residing with me.

N. B. - Certificate not applicable should be scored out.

Dated

ABV-INDIAN INSTITUTE OF INFORMATION TECHNOLOGY AND MANAGEMENT (ABV-IIITM), GWALIOR (MP)

CERTIFICATE - A

	P.F. No./ Roll No.:	:	
	Tel.:		
	Bank Name:		
	Account No.:		
Certificate granted to Shri/Smt./Kumari	(indicate relation)	of Shri/Dr.	

I, Dr.....hereby certify

- 1. That I charged and received Rs.....(Rupees only) for consultations at my consulting room/hospital OPD/patient's residence after hospital hours.
- 2. That the patient has been under treatment athospital/my consulting room and the under mentioned medicines by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient. These medicines were not stock in the ABV-IIITM Gwalior Health Centre for supply to the private patient and do not include proprietary preparation for which cheaper substance/substances of equal therapeutic value are available nor preparation which are primarily foods, toilets and disinfectants.

S. No.	Name	Qty.	Amount	R or NR*	S. No.	Name	Qty.	Amount	R or NR*
1					5				
2					6				
3					7				
4					8				
R =	R = Reimbursable, NR = Non-Reimbursable*								
3. 1	3. That the patient is/was suffering fromand is/was under my treatment								
f	rom	•••••	to						
4. 7	4. That the X-ray, Laboratory test etc. datedfor which expenditure								
C	of Rswas incurred were necessary and were undertaken								
C	on my advice, due to their non-availability of Health Centre.								
5. 7	hat I referre	ed the pati	ent to the				h	ospital whic	h is the
n	earest entitle	ed hospital	from the pla	ce where th	e patient	fell ill which	ch in my o	pinion could	provide
t	ne necessary	and suital	ole treatment.		-				-
6. 7	hat I referre	d the patie	ent to Dr			S	pecialist N	I. O. in Gove	ernment
e	mployment	in the				foi	specialist	consultation	
							-		

NAME OF MEDICINES (IN BLOCK LETTERS)

Signature and Designation of the Medical Adviser/Medical officer

(Fo	or Use in the A	ccounts Section)	
(a) Total amount of claim passed:(b) Less advance drawn, if any:(c) Net amount payable/recoverable:	Rs		
Checked by	Cla	aim Prepared by	
Please Pay Rs	(Rupees		
Dealing Hand Asst. Registr	ar	JR/Deputy Registrar	Registrar

Date: