Ref No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­

Medical Reimbursement for Hospitalization/OPD Treatment

|  |  |  |
| --- | --- | --- |
| Faculty : | | Department: |
| Medical reimbursement claim (Hospitalization or OPD): | | |
| Name of employee: | | Father’s name: |
| Account No. | |
| Name of patient (relationship): | | |
| Name of Hospital / city |  | |
| Name of Doctor |  | |
| Disease diagnosed /  Operation etc |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| S. No. | Bill No. | Type of Bill Claimed  (Doctor’s fee/Medicine/Lab Test etc) | Amount |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Total Amount Claimed (Rs.) | | |  |

Attach the required documents (in order):

1. Approval from the Competent Authority.
2. Doctor’s prescription (for OPD with diagnosis, date/sign/stamp)
3. Discharge summary (for hospitalized patients with complete particulars/diagnosis/

operation/procedure etc.)

1. Lab test Bills (in case of hospitalization only)
2. Medicine Bills (attach in order as mentioned above)
   * 1. Medicines (except medicines given on discharge summary) used during hospitalization must be endorsed by concerned doctor.
     2. OPD medicines should be in accordance with the doctor’s prescription.

Signature of Claimant Signature of the HOD/Chairperson/Principal

**FOR OFFICE USE:**

Remarks / Recommendations by the Committee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_