राष्ट्रीय प्रौद्योगिकी संस्थान दुर्गापुर

ন্যাশনাল ইনস্টিটিউট অফ টেকনোলজি দুর্গাপুর

NATIONAL INSTITUTE OF TECHNOLOGY DURGAPUR

Mahatma Gandhi Avenue, Durgapur – 713209, West Bengal, India

CLAIM FORM

(Application Form – Claiming Consultation Fees, Cost of Medicines/ Investigation Charge etc.)

A. Name of the Employee (in block letters): : _____

B. Employee ID No. : _____

C. Designation & Department / Section : _____

D. Medical Booklet No. of the Patient : _____

E. Full name of the patient relationship & Age : _____

F. Particulars regarding medical expenses : _____

Sl. No.	Name of the Medicine / Investigation / Consultation	Qty. / Nos.	Details of Expenditure, Cash Memo / Money Receipt No. & Date	Cost in Rupees
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
			Total	

(Rupees _____

_____ **only)**

DECLARATION: I do hereby declare that the patient is fully dependent upon me and his/her income from all sources including pension and pension equivalent of DCRG benefit and exclusive of the relief on pension sanctioned after January 1st, 2016 is less than Rs.9000.00 (Nine thousand only) plus the amount of Dearness Relief admissible on Rs.9000/- per month on the date of consideration of the claim.

Full Signature of the Claimant with Date

ESSENTIAL CERTIFICATE WITH REGARD TO THE MEDICAL REIMBURSEMENT AS IN PRE-PAGE

I hereby certify that:

a. The medicine(s) (as claimed for reimbursement on pre-page) prescribed in this connection were essential for the recovery/ prevention of serious deterioration of the patient. This/These medicine(s) is/are not stoked in the N.I.T. Medical Unit for supply to the patient.

b. The investigation(s) has/have been made on the basis of the recommendation of the Medical Officer (if applicable).

c. Prescribing authority of the medicine/tests as claimed whether it is by MO-N.I.T. Medical Unit or MO-DSPH or MO-SDH/ any Registered Medical Practitioner.

d. Name of the ailment from which the patient is/was suffering with regards to the claim _____

_____

e. Treatment period of the patient for which the claim in question is related from _____

f. The claim is in commensurate with the prescription in the medical booklet as mentioned by the claimant in pre-page.

Signature of the M.O./Registered Medical Practitioner with Date

N.B. i) Please strike out which are not applicable,

ii) Certificate(s) is compulsory and must filled in by the Medical Officer in all cases.

Admitted Rs. _____

(Rupees _____ only)

Joint Registrar (Estt.) / Registrar

Pay Rs. _____

(Rupees _____only)

Joint Registrar (Finance & Accounts)

Received Rs. _____

(Rupees _____ only)

Signature of the Claimant with Date

Paid Rs. _____

(Rupees _____only),

vide Cheque No. _____dated _____ under Cheque No._____ date _____

Joint Registrar (Finance & Accounts) / Registrar