**MEDICAL CLAIM FROM – INDOOR/OUTDOOR TREATMENT**

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| **I. Status Information of the Claimant** | | | |
| Claimant’s Name | Employee Code | Designation | Department |
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| --- | --- | --- | --- | --- |
| **II. Information regarding the patient** | | | | |
| Patient’s Name | Relationship | Nature of illness & its period | Name of Referring M.O/ Date | Referred Hospital Name |
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| **III. Hospital Expenses Information** | | | | | |
| **Sl** | **Particulars** | **Total Amount**  **(₹)** | **Sl** | **Particulars** | **Total Amount**  **(₹)** |
| 1 | Accommodation Bed Charges |  | 7 | Hospital Charges |  |
| 2 | Registration Fee |  | 8 | Physiotherapy Charges |  |
| 3 | Consultation / Doctor Visit Charges |  | 9 | Imaging Service Charges |  |
| 4 | Surgeon Charges |  | 10 | Blood Charges |  |
| 5 | Operation Theatre Charges |  | 11 | Miscellaneous Charges |  |
| 6 | X-Ray |  | 12 | Any other Charges Paid to Hospital |  |
| 13 | Diagnostic Charges |  | 17 | Medicine Provided by Hospital |  |
| 14 | ECG |  | 18 | Angioplasty Package Charges |  |
| 15 | Consumable Charges |  | 19 | Medicine Charges refund to Hospital |  |
| 16 | Test & Procedures |  | 20 | Cost of Medicine Purchased from market |  |
| **Total Amount Claimed** | |  | | | |
| **No. of Enclosures** | |  | | | |

Application for claiming reimbursement of medical expenses incurred in connection with medical attendance/ treatment for members of staff of the Indian Institute of Petroleum and Energy and their families.

**Notice**

* Attach all original bill receipts, Hospital reference & Xerox copy of discharge summary.
* Separate form should be used for each patient.

**Note:**

1.If the treatment was received by a member of the staff at his residence, give particulars of such treatment and attach certificate from the Authorised Medical Attendant, as required by rules.

2.If treatment was received at a Hospital other than a Government / Recognized Hospital, necessary details and the certificate of the Authorised Medical Attendant to effect that the requisite medical treatment was not available in any nearest Government Hospital should be furnished.

**DECALARATION TO BE SIGNED BY THE MEMBER OF THE STAFF**

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| --- |
| I hereby declare that the statement made 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 and is not an earning member of the family.  Date Claimant Signature |

**Consultant Comments (@ CGHS norms)**

**Medical Consultant**

**Countersigned and certified that the claim:**

(1) is genuine. (2) is covered by rules and orders on the subject. (3) is supported by bills, receipts and other certificates etc. (4) was not drawn before, and (5) has been sanctioned by competent authority.

**Competent Authority**

**Indian Institute of Petroleum & Energy**