# <u>MEDICAL CLAIM FROM – INDOOR/OUTDOOR TREATMENT</u>

I. Status Information of the Claimant										
Claimant's Name				Employee Code	Desig	Designation		Department		
II.	Information	regarding	the	patient						
Patient's Name Relationship				Nature of illness & its		Name	of	Referre	ed Host	oital
		1	period		Referring		Name			
					M.O/ Date					
TTT	Hospital Ev	nongog Info	rme	ation						
Sl	. Hospital Expenses Information Particulars Total Amount Sl Particulars To						Total A	Total Amount		
O.	T di tic	uiui s	_	(₹)		(3				
1	Accommodation Bed				7	Hospital Charges		•		
	Charges									
2	Registration Fee				8	Physiotherapy				
					_	Charges				
3	Consultation / Doctor				9	Imaging Service				
4	Visit Charges				10	Charges	~~~			
<u>4</u> 5	Surgeon Charges Operation Theatre				10 11	Blood Charges Miscellaneous				
3	Charges Theatre				11	Charges				
6	X-Ray				12	Any other	C	harges		
Ü					12	Paid to Hos		_		
13	Diagnostic Charges					Medicine Provided by				
						Hospital		-		
14	ECG				18	Angioplasty	Pa	nckage		
						Charges				
15	Consumable Charges				19	Medicine		harges		
1.0	T (0 D 1				20	refund to Ho				
16	Test & Proc	ceaures			20	Cost of	Me	dicine		
						Purchased market		from		
T	ı otal Amount	t Claimed				market				

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

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