

Ref. No. _____

Date: _____

FORM-I

(REIMBURSEMENT OF MEDICAL EXPENSES)

Application form for claiming reimbursement of medical expenses incurred in connection with medical attendance and/or treatment of employees and their families for medical attendance/treatment taken both from an Authorized Medical Attendant and a Hospital.

Employee Code: _____

Medical Health Card No. _____

1. Name and designation of NIT Uttarakhand employee	
a) Whether married or unmarried	
b) If married, the place where wife / husband is employed	
2. Office in which employed	
3. Pay of the employee as defined in the FR and any other emoluments which should be shown separately	
4. Place of duty	
5. Actual Residential Address	
6. Name of the patient and his/her relationship to the employee (in the case of children state age also)	
7. Place at which the patient fell ill	
8. Details of the amount claimed	
9. Date of Admission in the Hospital/Nursing Home	
10. Nature of Treatment/Disease (Surgery/Operation) etc.	
11. Whether treatment done at Empanelled hospitals or referred by Govt. Hospital/Authorized Medical Attendant	
I. MEDICAL ATTENDANCE	
1) Fees for consultation indicating	
a) the name and designation of the Medical Officer consulted and the hospital or dispensary to which attached	
b) the number and dates of consultation and the fee paid for each consultation	
c) the number and dates of injection and the fee paid for each injection	
d) whether consultations and/or injections were had at the hospital, at the consulting room of the Medical Officer or at the residence of the patient	
2) Charges for Pathological, Bacteriological, Radiological or other similar tests undertaken during diagnosis indicating	
a) the name of the hospital or laboratory where undertaken; and	
b) whether the tests were undertaken on the advice of the Authorized Medical Attendant. If so, a certificate to that effect should be attached.	
3) Cost of medicines purchased from the market (cash memos and the essentiality certificates should be attached)	

II. HOSPITAL TREATMENT	
Name of the Hospital	
Charges for hospital treatment, indicating separately the charges for	
1) Accommodation (State whether it was according to the status or pay of the employee and in cases where the accommodation is higher than the status of the employee, a certificate should be attached to the effect that the accommodation to which he was entitled was not available)	
2) Diet	
3) Surgical operation or medical treatment or confinement	
4) Pathological, bacteriological, radiological, or other similar tests indicating	
a) the name of the hospital or laboratory at which undertaken; and	
b) Whether undertaken on the advice of the Medical Officer/AMA Incharge of the case at the Hospital. If so, a certificate to that effect should be attached	
5) Medicines	
6) Special medicines (Cash memos and the essentiality certificates should be attached)	
7) Ordinary nursing	
8) Special nursing, i.e., nurses, specially engaged for the patient. State whether they are employed on the advice of the Medical Officer in charge of the case at the hospital or at the request of the Government servant or patient. In the former case a certificate from the Medical Officer in charge of the case and countersigned by the Medical Superintendent of the hospital should be attached	
9) Ambulance charges (State the journey to and fro-undertaken)	
10) Any other charges, e.g., charges for electric light, fan, heater, air conditioning, etc. State also whether the facilities referred to are a part of the facilities normally provided to all patents and no choice was left to the patient	
NOTE: 1. If the treatment was received by the employee at his residence under Rule 7 of the C.S. (MA) Rules, 1944, give particulars of such treatment and attach a certificate from the Authorized Medical Attendant (AMA) as required by these rules.	
NOTE: 2. If the treatment was received at a hospital other than a Govt. Hospital/necy. details and the certificate of the Authorized Medical Attendant (AMA) that the requisite treatment was not available in any nearest Govt. Hospital should be furnished.	
III. CONSULTATION WITH SPECIALIST	
Fees paid to a Specialist or a Medical Officer other than the authorized medical attendant indicating:	
a) The name and designation of the Specialist or Medical Officer consulted and the hospital to which attached	
b) Number and dates of consultation and the fees charged for each consultation	
c) Whether consultation had was at the Hospital or at the consulting room of the Specialist or Medical Officer, or at the residence of the patient and	
d) Whether the Specialist or Medical Officer was consulted on the advice of the Authorized Medical Attendant (AMA) and the prior approval of the Chief Administrative Medical Officer of the State was obtained. If so, a certificate to that effect should be attached.	

11. Total amount claimed ₹	(In Words)
12. Less advance taken on	
13. Net amount claimed	
14. Net of enclosures (i)	
(ii)	(viii)
(iii)	(ix)
(iv)	(x)
(v)	(xi)
(vi)	(xii)
(vii)	(xiii)
NOTE: 1. Income declaration for claims pertaining to dependence to be furnished in the prescribed form.	
2. Joint declaration to be furnished in the case of spouse employed in a Govt./autonomous organisation where similar facilities are available.	
Declaration to be signed by the NITUK Employee	
<i>I hereby declare that the statements in the 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. I or my dependent have not claimed any reimbursement for the above treatment from any other sources.</i>	
<i>The particulars/information furnished above is complete and correct and I have not suppressed any relevant information. Further, I am aware that, if at any stage the information/documents furnished above is found to be false, I am liable for disciplinary action under CCS (Conduct) Rules, 1964.</i>	
Date: _____	Signature of the Employee and Office to which attached
NB: Applications for reimbursement submitted after six months of treatment will be out rightly rejected, no communication in this regard will be made with applicant.	

Forwarded to Establishment Section

Counter Signature of HoD/Section Head

FOR OFFICE USE ONLY

A) Amount claimed: ₹ _____

B) Total amount reimbursed: ₹ _____

Nurse

Medical Officer