RAMANUJAN COLLEGE

(University of Delhi)
Accredited Grade 'A' by NAAC
ISO 9001-2008 certified organisation
Kalkaji, New Delhi - 110019
Ph-26430192, Fax: 26421826
Email id-ramanujancollege2010@gmail.com
Web-www.ramanujancollege.ac.in

For office use
Date of receipt of Medical Bill _____
Entered at Page No. _____ of Medical Bill Register

Form of Application for claiming reimbursement of medical expenses incurred in connection with medical attendance and/or treatment of college employees and their dependent family members

Separate form should be used for each patient
(Incomplete forms will not be processed for reimbursement)

1. (a) Name _____
   (b) Designation _____
   (a) Deptt. of Employee _____
2. (a) Whether married or unmarried _____
   (b) If married, the place where wife/husband is employed _____
   (In case employed, a joint declaration duly countersigned by wife's / husband's employer be submitted at the time of first bill during each financial year.
3. Pay in Pay band & Grade Pay of the college employee ₹_____
4. Name of the patient and his / her relationship to the College employee (In case of children, state age) _____
5. Place at which the patient fell ill _____
6. Whether member of W.U.S. health centre or not Yes/ No _____
7. Present Residential Address and Phone / Mobile number _____
   _____
8. Details of the amount claimed -
   (i) Fees for the consultation, indicating:
   (a) the name, qualification and designation of the authorized medical attendant/ medical officer consulted and the hospital or dispensary to which attached. _____
   (b) the number and dates of consultations and the fee paid for each consultation. Date _____ Consultation fee _____
   (c) the number and dates of injections and the fee paid for each injection Date _____ Injection fee _____
   (d) whether consultations and / or injections were had at the hospital/consultation room of medical officer or at the residence of the patient. _____
   (ii) Charges for pathological, Bacteriological, Radiological or other similar tests undertaken during the diagnosis indicating:
   (a) the name of hospital or laboratory where the tests were undertaken, and _____
   (b) Whether the tests were undertaken on the advice of the authorized Medical Attendant Yes/ No _____

(iii) **Cost of medicines purchased from the market** ₹ _____

List of Enclousers :

1. Prescription / OPD Card
2. Receipt of consultation fee
3. Receipt of laboratory test charges alongwith reports of diagnostic tests
4. Cash memo for purchase of Medicines
5. Discharge Summary in case of hospitalization **Total Amount Claimed** ₹ _____

Retired employee are eligible for medical reimbursement only if (member of WUS). Retired Employees to have furnish WUS Health Centre Membership No _____ Valid up to _____

Declaration to be signed by the college employee / retired employee

I hereby declare that the statements given in the application are true to the best of my knowledge and belief and that the person for whom medical expenses were in cured is residing with me and wholly dependant on me and his/ her income is less than ₹ 3500/- p.m. from all sources.

Date .....

Signature of Employee

Pre-receipt - If the amount claimed for reimbursement is ₹ 5000/- or above please affix a revenue stamp duly signed.

Notes:

1. All laboratory tests i.e. Radiological / Pathological / Bacteriological or other similar tests should be undertaken at Government hospital / University Panel hospital / University approved Diagnostic centres and Dispensaries. The amount paid for test done-in the laboratory of a panel doctor or private nursing home will not be reimbursed.
2. Time limit of three months for submission of medical claims from the date of completion of treatment should be strictly adhered to. Re-imbursement of claim not supported by enclosures as above shall not be allowed. Passed for payment of ₹_____ (Rupees_____)

(i) Consultation Charges ₹ _____
(ii) Medicine ₹ _____
(iii) Pathology/Radiological Test ₹ _____
(iii) Other Charges ₹ _____
Total ₹ _____

Burser **Administrative Officer** **Section Officer (Admin)** **Senior Assistant**

PRINCIPAL

"For use in Accounts"

Passed for payment for ₹ _____ (Rupees _____

_____) vide cheque no. _____ dated _____ Bank _____

S.O.A/cs **A/cs Asstt.**

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SUMMARY SHEET FOR MEDICAL REIMBURSEMENT

Patient's Name _____ Relation with Employee _____

Date of Treatment w.e.f. _____ upto _____

Patient is/was suffering from (name of Disease) _____

Name of the panel Doctor / Hospital _____

I. Date(s) of Consultation **Consulting Fee / ₹**

_____ _____

_____ _____

II. Name of Medicines **Cash Memo/Bill No.** **Date(s)** **Amount / ₹**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

III. Pathological / Radiological Tests etc. **Cash Memo/Bill No.** **Date(s)** **Amount / ₹**
(Reports in respect of Diagnostic test to be submitted alongwith the medical claim)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

IV. Other Charges _____

Total amount (I+II+III+IV) claimed : ₹ _____ (Rupees _____

_____)

Date _____ **(Signature of Employee)**

REMARKS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Date _____ **(Signature of Employee)**