Form: F.4

INDIRA GANDHI NATIONAL TRIBAL UNIVERSITY, AMARKANTAK (M.P.)

CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES

PART-A To be filled by the Employee			
Name of the Employee & Employee Code		Designation & Department	
Level		IPD Detail	
Name of Patient		Relationship with employee	
Mediclaim Policy No/Medical Insurance No. (If any in the name of employee/spouse)		Whether the claim has been reimbursed by the Insurance Co	YES/NO ……………..
If the medical expenditure has been claimed / already reimbursed(by any agency other than IGNTU, Amarkantak (M.P.). Details along with relevant documents and amount be mentioned.		• Total Claimed Amount in Rs.................... • Total reimbursed Amount in Rs................ • Agency Name……………………………... • Document Attached.....................................	

PROFESSIONAL, DIAGNOSTIC & MEDICINE EXPENSES

Nature of Expenditure	**Prescription / Reference by (Name of the Doctor)**	**Name of the Lab / Hospital**		**Medicines purchased from (Name of the Shop)**		**Bill No.**	**Date**	**Amount (Rs.)**
1. Specialist Consultation								
2. Lab.Test								
3. Medicines								
4. IPD Charges								
5. Room Charges (Excl./Incl. diet charges)								
6. Any other charges(i)								
(ii)								
(iii)								
(iv)								
						Total Amount (Rs)		
In Words :								

EMPLOYEES'S DECLARATION

Certify that I, Shri/Smt………………….employed in IGNTU, Amarkantak am not availing of medical facilities or financial/medical allowances in lieu thereof either for myself and/or the members of my family from any (other) source other than under the CS (MA) Rules, 1944. I also declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am agreeing for the reimbursement as is admissible under the university norms.

Total amount claimed (Rs)		Advance taken, if any (Rs)		No. of bills enclosed	

Date:
Place:

Signature of the Employee

Forwarded by controlling officer

PART-B
To be filled by the University Medical Officer

M.O./ University Doctor's CERTIFICATE

Patient suffered from (Name of disease)		From		To	

(For use by the University Medical /Health Unit)

I certify that the consultation/laboratory tests/medicines as claimed above were essential for the treatment of the patient, and that is respect of consultation/injections given at the residence of the patient, the condition of the patient were so serious that he/she was compelled to be confined to his/her residence. That the injections administered are not for immunizing or prophylactic purpose.

Date: **University Doctor with Seal**

PART-C
(For Use of Medical Cell Committee)

Amount Claimed Rs ___________________

Amount Admissible for payment in Rs ____________

Amount Admissible for payment in Word___________________

All bills have been examined and found in order and submitted for approval and sanction of the Competent Authority as per ceiling rate (Package Rate/Item wise Rate).

Signature of Medical Cell Committee

Approval by the Competent Authority

Vice-Chancellor

Forwarded to the Finance Office for payment

Note

1. All the medical claims along with requisite bills and other enclosures shall be certified by the employee concerned for examination and recommendation by the University Medical Officer in Part B.
2. Medical Cell Committee will examine the claim and forward the claims with admissibility of expenditure as per ceiling rate (Package Rate/Item wise Rate) defined in the CGHS/CS (MA) to the Finance Office with all relevant Original documents for further processing for release of payment.
3. Medical cell committee will attach the summary sheet of recommended amount (Item Wise) along with documents for record and one set of complete documents will be kept with Medical Cell.
4. The employee concerned have to furnish all the details/amount if the expenditure reimbursed by the insurance co. or any other organization/NGOs.
5. Hiding of fact or false claim shall attract disciplinary action by the competent authority.