NATIONAL INSTITUTE OF PLANT GENOME RESEARCH

New Delhi

FORM OF APPLICATION FOR MEDICAL REIMBURSEMENT CLAIM

1. Name and Designation of the Employee (In Block Letters) : …….

2. Whether married or unmarried : …….

3. If married, the place where wife/husband is employed : …….

4. Basic pay of the employee : …….

5. Residential Address : …….

…….

6. Name of the Patient with age and his/her relationship to the employee : …….

7. Nature of illness and its duration :……

8. A. (a) The name and designation of the Medical Officer consulted and the Hospital or Dispensary to which attached. : …….

(b) The number and date(s) of consultation and the fee paid for each consultation : …….

(c) Whether consultation/injection were had at the hospital or at the consultation room of the Medical Officer or at the residence of the patient : …….

(d) The number and dates of injections and the fee paid for each injection : ……...

(e) Charges of Pathological, Bacteriological, Radiological or other similar tests undertaken during diagnosis indicating the name(s) of :…….

(i) The Hospital/Laboratory where undertaken : ……..
(ii) The Authorised Medical Attendant (AMA) : ……..

B. IPD# : ……..

9. Cost of the medicines purchased from the Market : ……

10. Total amount claimed : …….

11. List of enclosures : (a) ……
(b) ……
(C) ……..…

Signature of the Employee

 # (In case of IPD, breakup details such as surgeon fees, room charges, laboratory tests, OT charges, etc; may also be provided).

MEDICAL REIMBURSEMENT CLAIM

11. Details of Medicine Purchased from Market

Sl.No.	Name of the patient and relationship with employee	Name of the drug store/chemist	Cash Memo No. & Date	Medicine(s)	Amount of each Medicine	Total of Cash Memo

(to be taken col 9 overleaf) **Total `**……

Rupees……..**Grand Total `**

……

DECLARATION

1. I certify that the patient(s) for whom medical reimbursement claim has been made in the bill is/are family members wholly dependent upon me.
2. I certify that my wife/husband is not employed in a Government/semi-Government service and he/she has not submitted any claim.
3. I certify that monthly contribution for medical fund is being deducted from my salary.

Date: Signature of the claimant

CERTIFICATE OF ESSENTIALITY*

After physical examination and study of prescription(s)/report(s) presented, it is certified that Dr./Mr./Ms/_____ is suffering from ailment _____ which comes under the purview of long treatment and needs constant and continuous medication.

Signature of Medical Consultant
NIPGR

* To be signed in case of treatment(s) exceeding 10/20 days