



राष्ट्रीय प्रौद्योगिकी संस्थान गोवा
NATIONAL INSTITUTE OF TECHNOLOGY GOA
कुनकोलिम, जिला दक्षिण गोवा, गोवा, पिन-403703
Cuncolim, South Goa District, Goa, Pin-403703

MEDICAL REIMBURSEMENT FORM FOR ADMITTED PATIENT (IPD)

(N.B. – Separate Form Should be used for Each Patient)

1. Name and designation of Employee :
(in block letters)
2. Department/Office in which employed :
3. Basic & Grade Pay /Level in Pay Matrix :
4. Residential Address :
5. Name of the patient and his/her relationship :
With Employee
(In case of children, please mention Date of Birth) :
6. Place at which patient fell ill :
7. Name of illness and duration :
8. Whether treatment was taken in emergency : ☐ Yes ☐ No
(If yes, attach certificate from treated Doctor)
9. Whether prior permission was taken for the treatment : ☐ Yes ☐ No
10. Name of Doctor and Hospital where treatment taken :
11. Details of the amount claimed for **Treatment as Admitted Patient :-**

Sr. No	Particulars	Name of Doctor/Clinic/ Hospital/Labs/ Pharmacy/etc.	Bill/Receipt no. and date	Amount Claimed (Rs.)	For Office Use Only (To be filled by Health Centre)	
					Amount Admissible as per CGHS rule (Rs.)	Remark of I.M.O. (if any)
1	Consultations					
2	Room Rent					
3	ICU Charges					
4	Diet					
5	Surgical operations/ procedures					
6	Ordinary Nursing					
7	Special Nursing					

8	Ambulance					
9	Pathological/ Bacteriological /Radiological/ Imaging or other similar tests undertaken					
10	Administrative					
11	Pharmacy					
12	Miscellaneous					
	(Enclose separate sheet if required)					
TOTAL						

12. Total amount claimed :

13. Number of enclosures :

Note –

- If treatment was received by the Government servant at his/her residence, give particulars of such treatment and attach certificate from authorised Medical attendant.
- Attach certified receipts, cash memos, prescriptions, referral letter from I.M.O, discharge summary, investigation reports, Essential Certificate-B etc. from the admitted hospital.
- The claim should be submitted within 6 months from date of completion of treatment.
- If special nursing required, attach the certificate from M.O. /Medical Superintendent of the hospital.

UNDERTAKING

- 1 I (name) _____ am a regular Employee of NIT Goa. I hereby declare that I am entitled for Medical Reimbursement claim from the Institution for self & my dependent family members. I also declare that any kind of excess payment made as reimbursement may be recovered as per the Institute norms.
- 2 I also declare that Shri/Smt./Master/Miss. _____ aged _____ years for whom the Medical treatment was taken is my _____ (relationship) and is fully depended upon me & his/her name is included as dependent in office records. I also certify that this Medical Reimbursement claim is made only at NIT Goa for entitled amount.

I hereby declare that the statements in application are true to the best of my knowledge.

Name and Signature of Employee

Forwarded by HoD

For Office Use only

1. It is verified from available office records that the claimant is a regular employee of NIT Goa and patient _____ is dependent of him/her.
2. The claim has been duly verified and the essentiality of the lab tests/ medicines/ injections etc. administered during treatment is certified. The claim has been regulated as per CGHS rates/Govt. of India orders, as applicable from time to time.

Verified the dependency

Checked the eligibility & admissibility

Establishment Office

Medical Officer, NIT Goa

Audited by

Recommended/Not-Recommended

Internal Audit Office

Registrar

Approved/Not Approved

Director

To: Finance & Accounts Section
