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 OPD PATIENT

(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 (If yes, attach certificate from treated Doctor) : ☐ **Yes** ☐ **No**
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 OPD Patient :-**

Sr. No.	Items	Name of Doctor/Clinic/ Hospital/Labs/ Pharmacy/etc.	Bill/Receipt no. and date	Amount Claimed	For Office Use Only (To be filled by Health Centre)	
					Amount Admissible as per CGHS rule	Remark of I.M.O. (if any)
1	Consultations					
2	Intravenous /Intramuscular/ Subcutaneous injections					
3	Pathological					

	/Bacteriological/ Radiological/ Imaging or other similar tests undertaken					
4	Pharmacy					
5	Miscellaneous					
(Enclose separate sheet if required)						
TOTAL						

12. Total amount claimed :
13. Number of enclosures :

Note –

- If treatment was received by the employee at his/her residence, give particulars of such treatment and attached certificate from Medical attendant.
- Attach all receipts, cash memos, prescriptions, referral letter from I.M.O., investigation reports etc. including Essential Certificate-A with this form.
- The Claim should be submitted within 6 months from date of each consultation.

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

Internal Audit Office *Recommended/Not-Recommended*

Registrar

Approved/Not Approved

Director

To: Finance & Accounts Section