FORM - A

DIBRUGARH UNIVERSITY

Dibrugarh | PIN – 786 004 | Assam

‘Application for claiming Refund of Medical Expenses incurred in connection with Medical Attendance and or Treatment of the Employees and their Families.’

(Separate form should be filled for each patient)

Name and designation of the employee (In Block Letters) :____

Employee ID No. :____

Deptt. / Centre / Branch / Section :____

Basic Pay :____

Residential address :____

____

____

Bank Account No.(SBI) :____

Name of the Patient :____

Relationship to the employee & his / her Medical Booklet Code No. :____

In the case of children, state age, date of birth and marital status :____

Place at which the patient fell ill :____

Nature of illness and its duration :____

Details of the amount claimed :____

Give details on a separate sheet of paper and Attach cash memos. :____

Details of Medical Advance Drawn (if any) :____

MEDICAL ATTENDANCE

(a) Name of Hospital :_____________________________________

(b) Name & designation of treating Physician/surgeon :_____________________________________

(c) The dates of Medical Attendance / Treatment : from ____________ to ___________

(d) Whether referred by the Dibrugarh University Health Centre, if not, reason for not getting referred.

DECLARATION TO BE SIGNED BY THE EMPLOYEE OF THE DIBRUGARH UNIVERSITY

I hereby declare that the statements in this application are true to the best of my knowledge and that Mr. / Mrs. / Miss ____ (Relation) ___________________ for whose medical treatment expenses were incurred is wholly dependent upon me.

(Signature of Employee)

NB: 1. Please enclose original OPD treatment Card of the hospital and Dibrugarh University Medical booklet of patient for necessary action by the Dibrugarh University.

2. All Indoor / Admitted patients should enclose original copy of discharge summary of the hospital.

CERTIFICATE FROM THE TREATING HOSPITAL / DOCTOR

(For Indoor / Admitted Patients only)

Certified that Shri / Smt.________________________________son / daughter / wife under my treatment (diagnosis) as an Indoor patient at ___________________________ Hospital.

Period of Hospitalization : from ______________________ to ______________________

All the bill / cash memos have been signed by me.

Signature

Name and Designation of treating Physician / Surgeon : ______________________________________

Please put your stamp in this space.

(Counter signature & Stamp of Medical Superintendent of Treating Hospital)

Employee ID No. : ______________________________________

Scrutinized & Entered by :

Signature : _______________________

Name : _______________________

Signature & Stamp of Medical Officer of Dibrugarh University Health Centre

(FOR ACCOUNT SECTION COPY)

Name & Department & Employee ID No. :______________________________________

S.N.	ITEMS	AMOUNT CLAIMED	AMOUNT ALLOWED	REMARKS / REASON
1.	Medicine			
2. (i)	Tests			
3.	Room Rent			
4. (i) (ii) (iii) (iv) (v)	Operation / Procedure charges etc. Operation Procedure ICU / CCU Consultation Others (Specify)			
	Total			

Passed and pay for Rs.________________ (Rupees ______________________________

________________________ only) and credited to the Saving Bank account of the SBI.

Dealing Assistant　　　　　　　　Accountant　　　　　　Asstt. Registrar / Accounts

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(INDIVIDUAL COPY)

Name & Department & Employee ID No. :______________________________________

S.N.	ITEMS	AMOUNT CLAIMED	AMOUNT ALLOWED	REMARKS / REASON
1.	Medicine			
2. (i)	Tests			
3.	Room Rent			
4. (i) (ii) (iii) (iv) (v)	Operation / Procedure charges etc. Operation Procedure ICU / CCU Consultation Others (Specify)			
	Total			

Passed and pay for Rs.________________ (Rupees ______________________________

________________________ only) and credited to the Saving Bank account of the SBI.

Dealing Assistant　　　　　　　　Accountant　　　　　　Asstt. Registrar / Accounts

Note : For any enquiry, please contact Account Section personally.
Column nos.1 and 2 have to be filled up by the individual.

FORM - B

DECLARATION FORM FOR SERVING EMPLOYEES FOR AVAILING THE MEDICAL FACILITY OF DIBRUGARH UNIVERSITY FOR SELF AND DEPENDANTS

I, ____ hereby declare that the following are the members of my family, who are residing with me and are wholly dependant upon me.

S.N.	Name of the Dependant	Relationship with employee	Date of birth	Married / Unmarried	Employed / Unemployed	In case the dependant is employed, please give the name and address of the organization

Note : *In case, the Spouse is employed, a certificate from the employer stating that the employee does not provide medical reimbursement facility to the employee shall have to be produced.*

The particulars of dependant members as given above are correct. It is also certified that the above dependants are residing with me. The residency proof of my parents and unmarried / widowed daughter(s) aged 30 years or more is also attached herewith. If any statement is found to be untrue, I shall be liable for disciplinary action.

Date : (Signature)

Name of the Employee & ID No.: ……………………….…………………………..

Designation : …………………..…………………………………………………

Dept. / Centre / Branch / Section : ……………………………………………..

Forwarded

(Head of the Dept. / Centre / Branch / Section)