Satyawati College
(University of Delhi)
Ashok Vihar, Phase - III
Delhi - 110052 (Phone : 01127219570)

Submitted by : .....

No. of Pages : .....

Date of Submission : .....

FORM OF APPLICATION FOR CLAIMING OF MEDICAL EXPENSES

PLEASE READ INSTRUCTIONS BEFORE FILLING THE FORM CAREFULLY & FOLLOW THE SAME.

1	Separate form should be used for each patient and each visit.
2	One visit, One Prescripition, One bill should be enclosed with a claim form. Please make it sure that the hospital, clinic, Doctor & laboratory are under the panel of Delhi University.
3	If the treatment was received by the employee at his residence give particulars, give particulars of such treatment and attach a certificate from the authorised medical attendant as required by these rules.
4	If the treatment was received at hospital, other than a Goverment Hospital necessary details and the certificate of the authorised medical attendant that the requisit treatment was not available in any nearest Government hospital, should be submited.
5	Note : 5 I. In case of special medicines an essential certificate should be attached : II. Numbering in the attached/submitted documents is compulsory.

FOR OPD TREATMENT & AUTHORISED MEDICAL ATTENDANT ONLY

1	Name of the employee :	
2	Designation :	
3	Mobile No. of the employee :	
4	Actual residence address :	
5	If married - the place where the wife/husband of the employee is employed (where applicable)	
6	Whether married or unmarried : Pay scale : basic pay & grade pay of the employee :	
7	Patient's Name and Relationship :	
8	Place at which the patient fell ill :	
9	Date of Birth of the Patient :	
10	Bank Name & Account No. in 16 Digit :	
11	Name & address of the doctor/Hospital :	
12	Date of consultation/visit of Doctor/Hospital :	
13	Consultation fee paid to the Hospital/Doctor :	
14	Injection fee Paid (if any) :	
15	Suffering from (Name of the Disease) :	

16	Period of Treatment/claim :	
17	Pathological test fee :	
18	Radiological test fee :	
19	Bactoeriological test :	
20	Name of the laboratory :	
21	Cost of medicine purchased (for the above mentioned period only) Rs.	
22	Any other charges (enclose detail & Bills)	
23	TOTAL No. of bill pages other than claim form :	
24	Total amount claimed :	

IN CASE OF HOSPITAL TREATMENT AS IN PATIENT :

1	Name of the Hospital	
2	Accomadation charges (No of days stay in the hospital)	
3	Diet Charges	
4	Nursing Charges (Ordinary or Special) (If spl. Enclose certificate)	
5	Ambulance charges (submit bill and certificate)	
6	Doctor's fee (No. of Days and No. of visit)	
7	Surgical Charges	
8	Medicines consumed at OT	
9	Medicines purchased (bills must attached)	
10	Surgical operation or medical treatment on fonfinement :	
11	Any other charges/expenditure on treatment (enclose detail & Bills)	

DETAIL OF LABORATORY TEST :

1	Pathological test fee :	
2	Radiological test fee :	
3	Bactoeriological test :	
4	Name of the laboratory :	

PLEASE MAKE IT SURE IF THE ABOVE LABORATORY IS UNDER THE PANEL OF DELHI UNIVERSITY OR NOT :

1	**TOTAL AMOUNT CLAIMED**	**RS.**

DETAIL OF MEDICINES PURCHASED :

(FOR IN PATIENT AND OUT PATIENT BOTH)

IT IS COMPULSORY TO FILL THE NAME OF THE MEDICINE IN CAPITAL LETTER

S. No.	Name of the medicines in CAPITAL LETTERS	Quantity	Cost	Remarks
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

Detail of enclosers duly countersigned by employee :

1	Prescripition of Doctor or Hospital :	
2	Cash Memos (No. of Memos) :	
3	Documents related to laboratory charges :	

1. I hereby declare that the above particulars are correct to the best of my knowledge and belief and that the person for whom medical expenses were incurred is residing with me and wholly dependent upon me and her/his income is less than Rs.3500/- per month from all source.

2. 5% empties of the used medicines as wrappers, vials, bottles are enclosed for verification and destruction as the amount has exceeded Rs. 500/- during the financial year. All the empties, as wrappers, vials, bottles are enclosed for verification and destruction as the amount has exceeded Rs. 1,000/- during the financial year.

Date of submission for Claim _____

Revenue stamp & Signature

For Office Use Only

1	Total amount claimed	
2	Less : Non-permissible amount	
3	Total amount passed	
4	Paid vide cheque No. & Date	

Dealing Assistant | S. O. Accounts | Administrative Officer | Principal