MEDICAL CLAIM REIMBURSEMENT FOR O.P.D. TREATMENT ONLY

NIDJ राष्ट्रीय डिज़ाइन संस्थान असम National Institute of Design Assam

FORM - 17

[Separate fo	rm should l	pe used for each patient - to be s	submitted to A	dmin.]
Name of the employee	: Emp ID			***************************************
Designation		Dep		
Pay Level				
Name of the Patient				
		Ci-		
		Since when ill		
Residential Address				
Nature of Illness	:			
Details of Medical Offic				
		onsulted :	Date	:
			Date	•
A. Consultation Charge Name of the Doctor Co	Date	Amount in Rs.		
		Hospital / Dispensary attached		
			_	
			Sub Total	
B. Pathological, Bacte	eriological	, Radiological or other (s) tes	t (s) undertak	en
Name of the Test (s)		Hospital / Laboratory where tests undertaken Date		Amount in Rs.
				1 1

Name of the medicine	Invoice no.	Date	Amount in Rs	
		Sub Total		
D. Any other charges				
Details (please specify)	Invoice no.	Date	Amount in Rs	
		Sub Total		
	Total Amount Claimed (A	A+B+C+D) in Rs.		
Total numbers of Money receipts / ir	voices enclosed			
rotal hambolo of Money roccipto, il	(All money receipt needs to be certified by the employee)			
	iod by the employee,			
(All money receipt needs to be certif	Please certify)	d that the person	for whom modi	
(All money receipt needs to be certif Total numbers of other enclosures (The information furnished above ar	Please certify) e complete and correct and	•		
(All money receipt needs to be certife Total numbers of other enclosures (The information furnished above are expenses were incurred is wholly described.)	Please certify) e complete and correct and ependent upon me. Furthe	r, I certify that for	the above clair	
(All money receipt needs to be certife Total numbers of other enclosures (The information furnished above are expenses were incurred is wholly despended to a	Please certify) e complete and correct and ependent upon me. Furthe ny other source (including e	r, I certify that for employer of my sp	the above clair ouse). I am awa	
(All money receipt needs to be certife to the certi	Please certify) e complete and correct and ependent upon me. Furthe ny other source (including educuments furnished above	r, I certify that for employer of my sp re is/are found to b	the above clair ouse). I am awa oe false, I shall	
(All money receipt needs to be certife Total numbers of other enclosures (The information furnished above are expenses were incurred is wholly do that if at any stage the information / liable for disciplinary action. I also an	Please certify) e complete and correct and ependent upon me. Furthe ny other source (including educuments furnished about athorize institute to make the	r, I certify that for employer of my sp re is/are found to b	the above clair ouse). I am awa oe false, I shall	
(All money receipt needs to be certif	Please certify) e complete and correct and ependent upon me. Furthe ny other source (including e documents furnished about athorize institute to make the	r, I certify that for employer of my sp re is/are found to be e payment directly	the above clair ouse). I am awa oe false, I shall	

FOR OFFICE USE ONLY (ADMN.)

The dependency has been verified from the office record and found to be correct.

Dealing Official Signature of CAO

FOR OFFICE USE ONLY (ACCOUNTS)

The admissible amount of reimbursement as per Institute rules is as follows:

Details	Amount Claimed in Rs.	Admissible Amount in Rs.	Admissible Amount as per institute rules in Rs.				
A. Consultation (s) fee(s)							
B. Test (s) charges							
C. Medicine Charges							
D. Other Charges							
E. Other Charges							
F. Other Charges							
	Ne	t Amount (in Rs.)					
In Word (Rupees Claim checked and found to be			• •				
Scrutinized by	Accounts	Officer	CFA				
Vetted by							
_	Institute Med	ical Officer					
For approval please							
Director / Registrar							