Maulana Azad NATIONAL INSTITUTE OF TECHNOLOGY

MEDICAL CLAIM FORM				Employee Code							
CORW					Designation						
Employee Name	ee				Department Contact No.						
Residence					SBI	BI					
Address					manufacture and a second secon	lank A/c No.					
					Pay in Pay Band						
Patient's Name					In case Patient is a child						
& Relationship with the employee						Date of			or Age must show		show
Patient Occ	upation				-		Number in order				
Monthly inco	-170-1171 (File 170-1171 170-1171 170-1171 170-1171 170-1171 170-1171 170-1171 170-1171 170-						th				
patient(All s	ources)			Total No children			Number o	of			
Nature of illness					lame of fedical officer		Trans.				
Duration of					lospital/						
illness				D	Dispensary						
illness hereby dec	lare that the	statement in person on wh	this appl	ration o	of the emplo are true to the enditure were	best	of my know	wledge	e and be	elief.	me.
I hereby decil further decil	are that the	person on wh	this appl nom med	ration o	of the emplo	best	of my know red is who	wledgolly de	e and be	t upon	
I hereby decil further decil	are that the	person on wh	this appl nom med	ration o	of the emplo are true to the enditure were	best of incur	of my knov rred is who	wledge olly de	e and be	t upon	
I hereby decil further decil	are that the	person on when the med Injection cha	this appl nom med	ration o	of the emplo	best of incur	of my know red is who	wledgolly de	e and be	t upon Si	
hereby decident further decident Date	Amount clair	person on when the med Injection cha	this appl nom med	ration o	of the emplo are true to the enditure were	best of incur	of my knor rred is who	wledge olly de	pendan	t upon Si	
hereby decident further decident Date Details of A A; Consulta 1. Consulta	Amount clair stion Fees &	person on when the med Injection cha	this appl nom med	ration o	of the emplo are true to the enditure were	best of incur	of my knov red is who	wledge olly de	pendan	t upon Si	
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Illness I hereby decident further decident Date Details of A A; Consulta 1. Consulta 2. Injection B: X-ray, La	Amount clair ation Fees & ation	med Injection cha Que ospital charge	this appi nom med rges uantity	lication a	of the emplo ere true to the enditure were	best of incur	red is who	olly de	Amo	Signature Signat	
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Illness I hereby decident further decident Date Details of A A; Consulta 1. Consulta 2. Injection B: X-ray, La	Amount clair ation Fees & ation boratory & h	ned Injection cha On On One	rges uantity es Cash I	Memo Date	Different of Name	best of Investment	red is who	olly de	Amo	Signature Signat	gnature

Name	of Medical	Cast	Memo	Name of	25000000					
/ Surg	/ Surgical Stores		Date	Medicines / Surgicals	Amount					
-										
				-						
						5				
Total Amount Cla	aimed by an En	ployee								
In Figure	In Word	ds								
	- 1	CERTIFIC	CATE BY DO	CTOR / HOSPITAL						
Certified that the above mentione treatment of the	d medicines, S	oned at form urgicals & In	n had been u nvestigations	nder my treatment as indoor had been prescribed were ab	outdoor patient a solutely essential	nd the for the				
Date			Signature of doctor with sea							
			For Institu	ite Use						
	Dispensa	ry								
	treatment on r	ny advice f	or which an was h	Cash memos & receipt ha verified. Payment of Rs May be approved.	ive been checks	d an				

Verified by

D.D.O.

N.B. (1) Separate form should be used for each patient (2) List of medicines cash memos and essentially certificate should be attached sequentially (3) All the columns are mandatory to fill.