भारतीय विज्ञान शिक्षा और अनुसंधान संस्थान कोलकाता

INDIAN INSTITUTE OF SCIENCE EDUCATION AND RESEARCH KOLKATA

Mohanpur- 741 246, Dist. Nadia, West Bengal, INDIA

FORM NO. 4

CONTRIBUTORY MEDICAL SCHEME - MEDICAL CLAIM FORM

MEDICAL REIMBURSEMENT CLAIMS FOR THE PERIOD FROM		**TO**
Name of Employee:		Type of Treatment:
Designation:	Emp. Code:	AGP/Grade Pay:
Name of Patient:	Age:	Relationship:
Duration of Illness: From To	Name of the Doctor:	

DETAILS OF TREATMENT	PARTICULARS	NO.	RATE	AMOUNT SPENT
Consultation at Clinic				
Consultation at Home				
Medicine(s)				
Pathological/ Radiological/ Other Test(s)				
Other (treatment at hospital/nursing home)				
Amount claimed:	**TOTAL ₹**			

Rupees	only.
Amount passed for payment: ₹	
Rupees	only.
Medical Officer Accountant AR (F&A) DR (F&A) Date:	Signature of Claimant Date:
Reimbursement Approved. REGISTRAR DIRECTOR	

Strike out whichever is not applicable.

Note: 1) Please use separate form for each Patient.

2) Claims should be supported by appropriate documents – prescription, receipts, relevant certificates, reference from Doctor for treatment by Specialists etc.

CHECK LIST - MEDICAL CLAIM FORM

Before submitting the Claim Form please go through the following points and ensure that the form is complete in all respect. Please put tick (✓) in the respective box.

1.	Type of treatment – Homeopathy/Allopathy/Ayurvedic *(as the case may be)* is written on the form.	
2.	All necessary details like name of the patient, relationship with the employee, age, name of the doctor, period of treatment, etc. are filled in.	
3.	Prescription(s) is (are) enclosed: Original/Photocopy *(strike whichever is not applicable).*	
4.	Complete receipt/bill/cash memo of medicines purchased corresponding to the prescription (s) is (are) enclosed.	
5.	Receipt of doctor's consultation fee in original *(if applicable)* is enclosed.	
6.	Photocopy of the original prescription, in case of chronic diseases *(if applicable)* is enclosed.	
7.	Investigation Bill *(if any)* is enclosed in original.	

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Signature of the claimant

Date:

Please print on reverse side of the Claim Form.