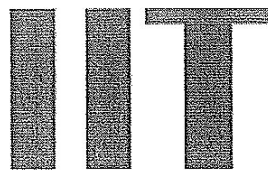




भारतीय
प्रौद्योगिकी
संस्थान
काशी हिन्दू विश्वविद्यालय



INDIAN
INSTITUTE OF
TECHNOLOGY
BANARAS HINDU UNIVERSITY

☎ : 91-542-6702069

FAX : 91-542-2367780, 2368428;

e-mail : registrar@itbhu.ac.in

Office of the Registrar

(M.R. Cell)

Ref. No. IIT(BHU)/MRC/3/2019-20/ 4658

कुलसचिव कार्यालय

(चिकित्सा प्रतिपूर्ति प्रकोष्ठ)

Dated: 20.08.2019

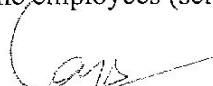
NOTICE

This is to notify that the existing provision of submission of medical reimbursement claim bills in UEHCC, BHU for the treatment taken in UEHCC/ S.S. Hospital/ Trauma Centre, BHU has been dispensed with. ***Now, all medical reimbursement claim bills of the Institute employees (serving/ retired) will be directly submitted in the Medical Reimbursement Cell, IIT(BHU).*** In case of OPD treatment taken in UEHCC/ S.S. Hospital/ Trauma Centre, BHU, 'NA' (Not Available) on the health diary for the medicines which are not available in UEHCC, BHU has to be followed, as per existing practice.

Further, existing medical reimbursement claim form for treatment taken in UEHCC/ S.S. Hospital/ Trauma Centre, BHU has been revised. The revised form is enclosed herewith. All the medical reimbursement claim bills of the treatment taken in UEHCC/ S.S. Hospital/ Trauma Centre, BHU are required to be submitted on the revised form.

All the employees (serving/ retired) are requested to take note of the above.

Encl: As above.


Joint Registrar (Admin.)-II

Ref. No. IIT(BHU)/MRC/3/2019-20/ 4658.

Dated: 20.08.2019

Copy to the following for information and wide publicity amongst the staff :

1. All the Deans.
2. All the Heads of Departments/Coordinators of the Schools.
3. The Chief Councilor, Gymkhana.
4. The Chairman, Senate Library Committee
5. The Chairman, IWC.
6. The Chairman, Council of Wardens.
7. The Chairman, Institute Cafeteria.
8. The Chairman, Web Management & E-mail Services Committee, for uploading on the Institute Website.
9. All the Prof. Incharges.
10. The Coordinator, Gandhi Technology Alumni Centre.
11. The Professor I/C, Main Workshop.
12. The Joint Chief Proctor.
13. The Administrative Wardens/Wardens of the Hostels.
14. All the Joint Registrars.
15. All the Asstt. Registrars.
16. P.S. to the Director.
17. IIT(BHU), VARANASI.
CMO I/c, UEHCC, BHU


Joint Registrar (Admin.)-II



INDIAN INSTITUTE OF TECHNOLOGY (BHU)

MEDICAL REIMBURSEMENT CLAIM FORM FOR TREATMENT IN S.S. HOSPITAL/ UEHCC/ Trauma Centre, B.H.U.

(To be filled in by the Employee / Pensioner)

1. Name of the Employee.....(Mob. No.....)
 (In capital letter)
 Employee / P.P.O. /CPF No.(D/O retirement, if pensioner.....)
 (As the case may be)
2. Designation & Department
 (Retired employees to mention Post & Department at the time of retirement)
3. (a) Patient's Name.....Age.....
 (b) Relation with Employee / Pensioner.....
4. Health Diary No.....
5. Particulars of the Treating Consultant (M.O's of UEHCC/S.S.H., Lecturer & upward of IMS.)
 Name.....Designation.....
 Department.....
6. For Hospitalization cases (S.S. Hospital)
 - a. Disease for which admitted.....
 - b. Date of admission.....Bed No.....Ward.....
 - c. Date of discharge.....(please attach a photocopy of discharge slip)
7. (a) Name of the disease from which patient is suffering.....
 (b) Whether any other claim has been submitted earlier..... Yes / No
 (c) Period of the treatment for which the Medical claim pertains From..... to.....
 (d) Amount of Present claim Rs.....

DECLARATION

I solemnly declare that:

- (a) The information furnished by me as indicated above is true and correct to the best of my knowledge and belief and if any information is found incorrect, I shall be held personally responsible.
- (b) The cash memos included in the claim are original, genuine and pertain to the treatment of self / my family member eligible for such benefit as per rules and he / she is solely dependent and residing with me at Varanasi.
- (c) No claim either in full or in part pertaining to the medical expenses on the treatment for this duration has been submitted earlier to the University or any other source for reimbursement either by myself or the patient.
- (d) Name of the dependent family member, for whose treatment this claim is preferred, is included in the list of family members submitted to the Institute.
- (e) **THE MEDICINES INCLUDED IN THE CLAIM WERE NOT AVAILABLE IN THE HEALTH CENTRE/ S.S. HOSPITAL.**

(Signature of the Employee / Pensioner)

Name.....

Designation.....

Department.....

Date.....

CERTIFICATE TO BE SIGNED BY THE HEAD OF THE DEPARTMENT / OFFICE
(Not applicable in case of retired employee)

Certified that Prof./Dr./Shri/Smt./Km.
(name & designation) is actually borne on the establishment of this Department / Office.....
..... and contribution towards medical charges @ Rs. is being
deducted from his / her monthly salary regularly and the patient in question is an entitled beneficiary.

Date.....

Signature of the
Head of the Department / Office with Seal

CERTIFICATE TO BE FURNISHED BY THE ATTENDING CONSULTANT

1. Certified that Dr./Shri / Smt./ Km. Age has
been under my treatment as O.P.D. / Indoor patient from to
2. This patient was found suffering from (name of disease).....
3. The Medicines and other investigations for which claim is preferred were actually prescribed by me and
after satisfying myself about the essentiality of the drugs prescribed and used by the patient. I have verified
and signed the cash memos submitted by the claimant.

Dated:.....

Signature.....

Name.....

Designation.....

Department.....

(Rubber Stamp)

TO BE FILLED IN BY THE MEDICAL RECORD OFFICE. S.S. HOSPITAL
(in cases of hospitalization in S.S. Hospital only)

1. On the basis of entries in the Hospital case sheet, it is certified that Prof./Dr./Shri/Smt./Km.
..... declared as (mention relationship)..... in the case sheet by the
University employee Prof./Dr./Shri /Smt. /Km. him / herself
was admitted in the S.S. Hospital and was discharged on.....
2. Certified that on verification from the treatment chart in the case sheet the medicine purchased as included
in the claim were actually prescribed.

Signature
Medical Supdt. S.S. Hospital (with Seal)

Date.....

Signature
Medical Record Officer (With Seal)

Date.....

List of enclosures

- a. All the Cash Memo duly signed and verified by the attending consultant with seal.
- b. Statement (in duplicate) showing (a) Cash Memo No. (b) Date (c) Amount (d) name of the each medicines /articles (as per cash memo clearly written and verified by the attending consultant.
- c. Photocopy of the cover page and relevant pages of the Health Diary where treatment prescribed by the treating consultant pertaining to present claim.

NOTE

- In OPD cases, reimbursement for only those medicines will be made which are not available in UEHCC, BHU.
- Medicines prescribed at least for 5 days and above Rs.500/- (both the conditions should be fulfilled) will only be reimbursed, except accidental, emergency and chronic cases.

FOR USE BY MEDICAL REIMBURSEMENT CELL, IIT (BHU)
(Major Head – *Plan-OH-36(Recurring)* & Minor Head – Medical treatment)

1. Name of recipient:
(In capital letter)
2. Amount of total claim :
3. Amount not admissible :
4. Claim admitted for :
5. Deduction of Advance if any ; Rs.....
6. Passed for payment of Rs.....(Rupees).....
.....

Dy. Registrar (Accounts) /
Asst. Registrar (Accounts)

Section Officer/ Checker
MR Cell