

VALLABHBHAI PATEL CHEST INSTITUTE
UNIVERSITY OF DELHI
DELHI-110007

Annexure-I

MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. WUS Health Centres Card No
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 2. Validity of WUS Health Centres Card (For pensioners) from : to
& Entitlement Private / Semi Private / General
 3. Full Name of Card Holder (Block Letters)
 4. Status (College / University Employee / Pensioner / Temporary / Permanent)
 5. The following document are submitted (Please tick (✓) the relevant column)
- | | |
|--|----------|
| (a) Medical 2004 Form | YES / NO |
| (b) Photocopy of WUSHC card | YES / NO |
| (c) No. of Original Bills | ----- |
| (d) Copy of discharge summary | YES / NO |
| (e) Copy of referral by Specialist / CMO | YES / NO |
| (f) Whether the hospital has given breakup for lab investigations | YES / NO |
| (g) Original papers have been lost the following documents are submitted | |
| I.) Photocopies of claim papers | YES / NO |
| II.) Affidavit on Stamp Paper | YES / NO |
| (h) Incase of death of card holder the following documents are submitted | |
| I. Affidavit on Stamp paper by Claimant | YES / NO |
| II. No objection from other legal Heirs on Stamp papers | YES / NO |
| III. Copy of death certificate | YES / NO |

Signature of WUS Health Centres Card Holder/Employee

Dated :

Telephone No.(O) _____

(R) _____

Name of the Bank:

Branch :

SB A/C No. :

Branch MICR Code :

Tel. No. of Bank Branch

VALLABHBHAI PATEL CHEST INSTITUTE
UNIVERSITY OF DELHI, DELHI - 110 007

Medical 2004 Form for Reimbursement of Medical Claims

COMPUTER No. _____

(To be filled by the Claimant)

1. WUS Health Centres Card No.:
2. Validity of WUS Health Centres Card: From _____ To _____
& entitlement : Private / Semi Private / General
3. Full name of the Card holder (Block Letters) :
4. Full Address : _____
5. Telephone No. : (O) _____ (R) _____
6. E-mail address, if any _____
7. Name of the Bank : _____ Branch: _____ SB A/c : _____
8. Name of the Patient & relationship with the card holder _____
9. Status tick (✓) University Employee / Pensioner / Legal Heir / Others
10. Basic Pay / Basic Pension :
11. Name of the Hospital with Address :
(a) OPD treatment and investigations : _____
(b) Indoor Treatment _____
12. Date of admission _____ Date of discharge _____ In case of Indoor Treatment only) _____
13. Total Amount Claimed
(a) OPD treatment and investigations : _____
(b) Indoor Treatment : _____
14. Details of Referral : _____
15. Details of Medical advance if, any : _____

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am a WUS Health Centres beneficiary and the WUS Health Centres card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Date : _____

Signature of WUS Health Centres Card Holder / Employee

Note : Misuse of WUS Health Centres facilities is a criminal offence. Suitable action including cancellation of WUS Health Centre card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employee.



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UNIVERSITY OF DELHI, DELHI - 110 007

REIMBURSEMENT OF MEDICAL BILL

1. Name of the Employee :
2. Name of the Patient :
3. Diagnoses :
4. Relationship :
5. Doctor's Name/Hospital :
6. Period of Treatment :

(Signature of the Employee)

	Amount of the Bill	Amount Passed by the institute
a) Consultations		
b) Injection Inoculation		
c) Laboratory Tests		
d) Radiology (X-Rays)		
e) E.G.C. Charges		
f) ECHO Doppler		
g) Ultra Sound (Upper/Lower/Total)		
h) Accomodation		
i) Medical Care		
j) Spl. Consultations		
k) M.R.I.		
l) Operation Charges		
m) O. T. Charges		
n) Anesthesia Charges		
o) Oxygen Charges		
p) CAT Scan		
q) MEDICINES		
r)		
s)		
TOTAL		

ACCOUNTS ASSTT.

S. O. ACCOUNTS

A. R.

Received Payment

Signature of the Employee



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UNIVERSITY OF DELHI
DELHI - 110 007

Form of the application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment of institute employee and their families

1. Name and designation of the employee :
(in block letters).

i) Whether married or unmarried

ii) If married the place where wife/husband of the employee is employed (Where applicable)
(in case, employed, a joint declaration duly countersigned by the wife employer husband, of the child may be furnished) at the time of first bill in each financial year.

2. Where employed :

3. Pay of the Institute employee, and any other emoluments, which should be shown separately :

4. Place of duty :

5. Actual residential address :

6. Name of the patient and his/her relationship to the University/ College employees.

B. - In the case of children state age also.

7. Place at which the patient fell ill :

8. Whether member of W.U.S. Health Centre or not.

9. Is there any Med. Store run by the Coop. Society OR Govt. within 2 kms. from the residence of the claimant ?

10. C. Details of the amount claimed :

I. Medical Attendance :

(i) Fees for consultation, including :

(a) the name, qualification and designation of the medical officer consulted and the hospital or dispensary to which attached

(b) the number and dates of consultation and the fee paid for each consultation.

(c) the number and dates of injection ; and the paid for each injection.

VALLABHAI WATEL CHEST INSTITUTE



(d) Whether consultations and/or injections were held at the hospital, at the consulting room of the medical officer or at the residence of the patient.

ii) Charge for Pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating :

(a) the name of the hospital or laboratory where undertaken, and

(b) Whether the tests were undertaken on the advice of the authorised medical attendant. If so, a certificate to that effect should be attached.

iii) Costs of medicines, purchased from the market.

(list of medicines, cash memos, and the essential certificates should be attached)..

11. Diagnoses

12. Total amount claimed :

13. List of enclosures :

DECLARATION TO BE SIGNED BY THE INSTITUTE EMPLOYEE

I hereby declare that statement in this application are true to the best of my knowledge and belief and that the

Date20

(Pre-Received)

Signature of the Government servant and office to which attached

Signature of the Controlling Authority with office seal.

Cheque Signing Officer