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

## REIMBURSEMENT OF MEDICAL BILL

1. Name of the Empolyee : .....
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*

# 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 .....
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. : _____

Brach 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.***

Accounts Form No. X

# VALLABHBHAI PATEL CHEST INSTITUTE
## 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. .....

(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

(Pre-Receipted)

Date .....20

*Signature of the Government servant and office to which attached*

**Signature of the Controlling Authority with office seal.**

***Cheque Signing Officer***