Form-MRC(S)
(For Employees)

Indira Gandhi Delhi Technical University for Women
Kashmere Gate, Delhi

1. (a) Name of the Employee :
   (b) Medical Card Number :
   (c) Employee Code :
   (d) Designation :
   (e) Ward Entitlement – (Pvt/Semi. Pvt./General) :
   (f) Branch Posted at :
   (g) Full Address :

   (h) Mobile/Telephone and e-mail address if any :
   (i) Basic Pay (Excluding AGP) :

2. (a) Patient's Name :
   (b) Relationship with the Employee :

3. (a) Name & Address of the hospital/diagnostic centre/imaging centre where treatment is taken or test done :

4. Whether the hospital/diagnostic/imaging centre is empanelled under University/DGHS/CGHS :
5. Treatment for which reimbursement is claimed :
   (a) OPD Treatment/Test & Investigations and period of treatment :
   (b) Indoor Treatment (Date of Admission & Date of Discharge) :
6. Whether treatment was taken in emergency :

7. Whether prior permission was taken for the treatment (Yes/No) (If yet copy of approval may be enclosed with the claim form) :
8. Whether subscribing to any health/medical insurance scheme. If yes, amount claimed/received :
9. Details of Medical Advance taken, if any :
10. Total amount claimed :
    (a) OPD Treatment (Summary Sheet may be enclosed separately with the claim form) :
    (b) Indoor Treatment (Summary Sheet may be enclosed separately with the claim form) :
    (C) Tests/Investigation :
11. Total amount claimed :
    (a) Name of the Bank :
    (b) SB A/c No. :
    (c) Branch MICR Code :
    (d) IFSC Code :

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 University Medical Scheme beneficiary and the Medical Card was valid at the time of treatment. I agree for the reimbursement as is admissible under rules.

Date : _____ Signature of the Employee

Placed : _____

Documents to be attached

1. Photocopy of University Medical Card.
2. Copy of permission letter if any.
3. Emergency Certificate (original), in case of emergency.
4. Copy of the Discharge Summary.
5. Ambulance Certificate (original), if any.
6. Original bills/cash memo/vouchers etc. for the reimbursement amount claimed.

IMPORTANT

Kindly ensure to provide the following documents, wherever applicable:

(a) Obtain break up of investigations from the hospital/diagnostic centre/imaging centre (details and rates on individual tests and the exact number of tests, x-ray films, etc.) as the reimbursable amount is calculated as per approved rates per test.
(b) In case of loss of original papers. Affidavits as per Annexure-I to be submitted. All photocopies of the bills to be attested by the treating doctor/specialist.
(c) In case of death of the card holder, Affidavit as per Annexure-II to be filled and attached to claim reimbursement.
(d) In case of implants, invoice No. alongwith sticker with serial number of the implant to be attached (in original).
(e) In case of Coronary Stents, outer pouch of stents to be enclosed.
(f) In case of replacement of pacemaker/ICD etc. Copy of the warranty certificate of earlier pacemaker/ICD may be enclosed.

Note: Misuse of University medical facilities is a criminal offence. Penal action including cancellation of Medical Card may be taken in case of wilful suppression of facts or submission of false claims/statements.

Annexure-I

Draft for Affidavit for Duplicate Claim Papers/Bills on Stamp Paper

I _____ Son/Wife/Daughter of _____ and resident of _____ have lost/misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim papers from any source and that if the original papers are traced. I shall not stake claim against original bills in future and that in the event, I receive any cheque against the original bills in future, I shall return the same to Competent Authority.

Deponent

Verified by Notary Public

Annexure-II

Draft for Affidavit on Stamp Paper for claiming medical reimbursement in case of Death of a University Employee/Dependent

I _____ Husband/ Wife/ Son/Daughter of Late _____ and resident of _____ hereby submit the medical reimbursement claim papers pertaining to treatment of my Husband/Wife/Father/Mother Late Shri/Smt. _____ who has expired on _____ (copy of Death Certificate is enclosed).

Late Shri/Smt. _____ has left behind the following other legal heirs, none of the whom have any objection if the entire reimbursable amount is paid to me.

No objection Certificate signed by other legal heirs on Stamp Paper is enclosed.

Deponent

Attested by Notary Public

Draft for No Objection Certificate on Stamp Paper.

We (i) _____ S/o D/o Late Shri _____

(ii) _____ S/o D/o Late Shri _____

(iii) _____ S/o D/o Late Shri _____

(--) _____

(--) _____

(--) _____

Being the legal heirs of Late Shri/Smt. _____ have no objection if the entire amount reimbursable pertaining to the treatment of late Shri/Smt. _____ is paid to Shri/ Smt. _____.

(i) (Signature) Name: Address:	(ii) (Signature) Name: Address:	(iii) (Signature) Name: Address:
(iv) _____	(v) _____	(iv) _____

Verified by Notary Public