MEDICAL REIMBURSMENT BILL

Note: - 1. Pl. enclose latest Reference Letter from AHC.
2. Original bills/cash-memos. may be submit while claiming the bill with date-wise prescription.

JAMIA MILLIA ISLAMIA
NEW DELHI

FINANCE & ACCOUNTS OFFICE

Dispatch No. ……..…Dt.....……

Diary/BRF No. ……Dt……

Re-Received Date……..

Passed /Approved Date…….……

DEBIT

Major Head.....**Common Service**……..... ₹

Minor Head……...…**Medical Reimbursement Accounts**…….……

Amount in Words: Rupees……..……

CREDIT

In favour of ……...……...……

Emp. ID No.....(Bank A/C No)…….……

Indian Bank J.M.I Branch. Ch. No……...……...…Date……..

Medical Advance Rs…….……...…Date of Drawal……..……..…..

TOTAL

F.D.R. No. ……... I.L. No. …….. L.F. No. ……..…..…

Voucher prepared by……..dated ……..…….....

Certified that:

1. The balance under the Head of expenditure upto dated is Rs…….according to the books of the office. before sending the bill under reference.

…….. ……... …….....

Financial Authority date: …….. Dy. Registrar/Asstt. Registrar dated: ……..... Registrar date: .....

Checked by……..... dated……

Dealing Assistant……..... dated……...…….

Pay by Cash/ Cheque ₹ ..... ₹ …….....

Transfer / Adjustment…….....

……. …….

Section Officer **Accounts Officer** **Date……**

Received from the **JAMIA MILLIA ISLAMIA, NEW DELHI-110025** the sum of

₹…… Date…….

Thumb Impression of……...…….. Revenue Stamp attested…….

Signature

STATEMENT OF RECEIPTS & BILLS SUBMITTED

Sl. No	Cash Memo or Bill No. with Date	Name of the Suppliers	Particulars	Amount Rs.	P.	Remarks

JAMIA MILLIA ISLAMIA

Maulana Mohammad Ali Jauhar Marg
New Delhi -110025

APPLICATION FORM FOR MEDICAL CLAIMS

Application form for reimbursement of medical expenses / treatment of Jamia employees and their family by authorized medical doctors and the hospital recognized by the Jamia.

1. (a) Name…….....
(Name in block letters)

(b) Designation …… Nature of Appointment …….....

(c) Department / Office Posted …….....

(d) Residential Address……..

Telephone Nos. (Residence) ……..…….. Mobile No……..

(e) Family Declaration Register No……

(f) If married the place where
Wife /husband /spouse is employed ……

(g) Department /Office / Salary drawn……...

2. Basic Pay and other emoluments …….

3. Patient's name and his/her relation to the
Employee (NB in the case of children mention age)……

4. Details of the Amount Claimed……

Medical Attendance:

(a) Name and designation of the medical
Officer consulted and the hospital /
Dispensary to which attached ……

(b) Number and date of consultation
and the fee paid for each consultation……

(c) Number and dates of injection and
the fee paid of each injection……..

(d) Whether consultation and /or injection were had at the hospital at the consulting at the residence of the patient **…….....**

(e) Charges for pathological, bacteriological, radiological or other similar tests undertaking during diagnosis indicating**……**

(i) the name of hospital or Laboratory where undertaking **……..**

(f) Cost of medicines purchased from the market (enclosed cash Memo and the essential certificate**)……**

5. Total amount claimed Rs**…….....**

6. List of enclosures**……..……...**

Declaration and Certificate to be signed by the Jamia Employee.

I hereby declare that the above statement is true to the best of my knowledge and belief and that person for whom medical expenses were incurred is wholly dependent upon me.

Certified that I **……..……** (name) employed

in**……..** (name of the office in which employed)

am not availing of medical facilities or financial /medical allowance in lieu there of either for myself and /or the members of my family any other source (other than under C.S.(M.A.) Rules, 1994.

Dated**……** **……**

Signature of the Jamia Employee