भारतीय विदेश व्यापार संस्थान

(मानित विश्वविधालय)

बी-21, कुतुब इंस्टीटयुशनल एरिया, नई दिल्ली-110016

INDIAN INSTITUTE OF FOREIGN TRADE

(Deemed to be University)

B-21, Qutub Institutional Area, New Delhi – 110016

MEDICAL REIMBURSEMENT CLAIM FORM
(to be filled up by the Principal Card holder in BLOCK LETTERS)

1.	Name of the Retired Employee	
2.	Ward Entitlement- Private/ Semi-Private/General	
3.	Full Address	
4.	Mobile/telephone no. and e-mail address, if any.	
5.	Patient's Name	
6.	Patient's ID No.	
7.	Relationship with the Principal card holder	
8.	Name & Address of the hospital/diagnostic center/imaging center where treatment is taken or tests done.	
9.	Whether the hospital/diagnostic/ imaging center is empanelled under CGHS	
10.	Treatment for which reimbursement claimed Indoor treatment	
11.	Whether treatment was taken in emergency	
12	Whether subscribing to any health/medical insurance scheme, if yes, amount claimed/received.	
13	Total Amount claimed	

Name of the Bank : _____S/B Account No. _____

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 IIFT beneficiary and the IIFT card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Date :

Place: Signature of the Principal IIFT Card Holder

Documents to be attached

1. Photocopy of the IIFT Card of the employee along with the patient's IIFT Card
2. Emergency certificate (original) in case of emergency.
3. Copy of the discharge summary
4. Ambulance certificate (original) if any.
5. Original bills/cash memo/vouchers etc. for the reimbursement amount claimed.

IMPORTANT:

Kindly ensure to provide the following information/documents, wherever applicable:

a) Obtain Bank up of investigations from the hospital/diagnostic center/imaging center (details and rates of individual tests and the exact number of tests, X-ray films, etc.) as the reimbursable amount is calculated as per approved CGHS rates per tests.

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.

e) Case of Coronary Stents, outer pouch of stents is 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 facilities is a criminal offence. Penal action including cancellation of card may be taken. In case of willful suppression of facts or submission of false statements for retired employees.

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ACKNOWLEDGEMENT
(To be handed over to the employee on submission)

NAME: **PURPOSE:**

DAIRY NO: **DATE:**

(Signature of Dealing Assistant of Finance Division)

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 any 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