** Indian Institute of Technology Hyderabad**

Kandi – 502 284

**Student Medical Claim Form for OP**

(To be completed in the case of a patient who is **not admitted to the hospital** for treatment)

Please fill all the fields. The incomplete form shall not be entertained

The claim should be submitted within **One month** from the date of completion of the treatment.

**PART-A**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of the Student | Course | Department | Roll No. |
|  |  |  |  |

|  |  |
| --- | --- |
| Name of the treating Doctor |  |
| Name of the disease/treatment (or) |  |
| In Case of Injury, state the time and Place of Occurrence |  |
| Duration of treatment | From date: |  | To date: |  |

**Treatment and Claim Particulars**

1. **Details of Consultation and injection(s) fee:**

(Attach a separate sheet if required)

|  |  |  |  |
| --- | --- | --- | --- |
| Sl. | Date | Fee paid for Consultation | Fee paid for intravenous/Intra-muscular/Subcutaneous injections |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

1. **Details of medicines:**

(Attach a separate sheet if required)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. | Name of the medicine | Qty | Price | Date | Invoice/Bill No. |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |

Contd..2

-2-

1. **Details of x-ray, laboratory tests, investigations, etc.:**

(Attach a separate sheet if required)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sl. | Name of the test | Amount | Date | Invoice/bill No. |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |

**Total Claim Amount (**a+b+c**) = \_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

 Advance if any availed Yes/No. If yes, amount Rs.\_\_\_\_\_\_\_\_\_\_.

**Documents to be enclosed:**

1. Self-attested photocopy of Referral/Approval of the Institute Medical Officer/Dean Admin/Director.
2. Self-attested photocopy of the Prescriptions/OP note/treatment note.
3. Original cash memos/receipts.
4. Self-attested photocopy of ID card.

**Bank Details of the Student:**

|  |  |
| --- | --- |
| Account Holder Name |  |
| Bank Account No  |  | IFSC Code |  |
| Bank Name |  | Branch |  |

 Signature of Student

Contact No.:

Date:

**PART-B**

I certify that the above pathological tests prescribed by me to arrive at the correct diagnosis.

I also certify that patient has been under treatment as prescribed by me and above medicines are purchased due to non-availability at our Dispensary.

Signature of the Medical Officer

 Name: