MOTILAL NEHERU COLLEGE (Eve.)
UNIVERSITY OF DELHI
BENITO JUAREZ MARG, NEW DELHI-110021

1. Name of the Employee _____ SBI A/c No. _____

   Designation _____ B.Pay _____ allowances _____ total _____

2. Date of Submitting the Bill/Bills _____ Nature of Bill _____

   No. of Bill/s _____

Details of Bill/s

Bill No. & Date	Name of the patient	Relationship	Amount

Amount disallowed with the reason(s) from Bill No.

Lab Test _____

Consultation _____

Medicine _____

Others _____

_____

Total Rs. _____

_____

Permissible expenditure of total Bills Rs. _____

Bill/s entered in the Medical Register at Page No. _____ **Sl. No.** _____ **Vr.No.** _____ **Date** _____

Dealing Asstt.

Passed for payment of Rs. _____ **debitable to Medical Reimbursement A/c**

Asstt. **Sr. Asstt.** **S.O. (Acctts.)** **S.O.(Admin)** **A.O.** **A.O.** **Bursar** **Principal**

_____

Received Rs. _____

Signature of Employee

MOTILAL NEHRU COLLEGE (Eve.)
UNIVERSITY OF DELHI

MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS

COMPUTER No.

(To be filled by the claimant)

1. WUS Health Centre Card No. :
2. Validity of WUS Health Centre Card: & entitlement: From _____ To _____
   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. : _____
   Branch MICR Code : _____ Tel. No. of Bank Branch _____
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 investigation : _____
    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 Centre Beneficiary and the WUS Health Centres card was valid at the time of the 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 centre card shall be taken in case of willful suppression of facts or submission of false statements. Suitable action shall be taken in case of serving employee.