मोतीलाल नेहरू राष्ट्रीय प्रौद्योगिकी संस्थान इलाहाबाद
प्रयागराज–211004 भारत,
Motilal Nehru National Institute of Technology Allahabad
Prayagraj-211004 [India]

Format for Medical Reimbursement for OPD Treatment

1. Name of the Employee:-
2. Employee ID
3. Card/ Booklet Number
4. Designation:-
5. Department/office:-
6. Pay Scale:-
7. Details of medical treatment
   a) Name of the Patient:-
   b) Relationship with employee :-
   c) Date of consultation at HCC:-
   d) Duration of the Treatment:-
   e) Amount Claimed for:-
   (Claim should be submitted within six months)

Name of Medicines	**Amount claimed**

I hereby declare that above particulars are correct to the best of my Knowledge and beliefs and in case if it is found that claim has been wrongly sanctioned to due to any mistake from my part, I shall refund with penal interest to the institute and liable for any legal action .

Signature of the Claimant

For the office use of Health Centre

I, Dr.______________________ hereby certify that patient has been under treatment at ___________________________and was suffering from ________________during ________to____________ and above mentioned medicines prescribed were essential for treatment of the patient. The aforesaid medicines were not available at HCC and hence I recommend to consider his claim for Rs ___________

Claim in original is hereby forwarded to Accounts Section for further necessary action.

Signature of concerned official **Signature of MO**
Health Centre, MNNIT

For the office use of Accounts section

Bill claim of Rs ___________in respect of ______________ is passed for payment.

Signature of Dealing Head **Signature of Assistant registrar**