

**INDIAN INSTITUTE OF INFORMATION TECHNOLOGY,  
KALYANI**

**Medical Reimbursement Form - INPATIENT /HOSPITALISATION**

(Separate form should be filled for each patient)

Name :	Employee ID:
Designation with Department :	E-Mail ID:
Date of submission:	Mobile:

Name of the patient:	
Patient's Relationship With The Applicant:	
Name & Address Of The Hospital/Diagnostic Centre/ Imaging Centre Where Treatment Is Taken Or Tests done:-	
Treatment For Which Reimbursement Claimed :	
Whether Subscribing To Any <b>Medical Insurance</b> Scheme, If Yes , Amount Claimed /Received from Insurance	
Total Amount Claimed	
Date of Admission :	
Date of Discharge :	

I (name) \_\_\_\_\_ am a regular Employee/Officer of IIIT Kalyani. I hereby declare that I am entitled for Medical Reimbursement claim from the Institution for self/my dependent family members. I also declare that any kind of excess payment given to me in Medical Reimbursement claim may be recovered according to the norms of the Institution.

Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_

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Inpatient/Hospitalization\*:

Sl. No	Date	Particulars	Details	Amount (in rupees)	Amount claimed
a		Room rent	_____ Days x Rs. _____/Days		
b		Consultation	_____ Consultation x Rs. _____/ Consultation		
c		Operation / Procedure expenditure			
d		Other ( specify)			

\*Use separate sheet, if needed.

Total Amount Claimed for hospitalization: RS \_\_\_\_\_

Amount in words \_\_\_\_\_.

Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_

**CHECKLIST:**

- 1. Original Tax invoice for medicine and investigations - Yes/No.**
- 2. Money receipt for doctor fees -Yes/No.**
- 3. Discharge summary - Yes/No.**
- 4. Doctor prescription – Yes/No.**
- 5. If any other documents, please specify.**