

For Retired Employee

MEDICAL REIMBURSEMENT BILL
REVENUE A/C
BANK A/C No. 443244331
GRANT -IN-AID SALARY



REGISTRAR OFFICE

PFMS Voucher No.

MIS Dispatch No. Dt.

Diary/BRF No. Dt.

Re-Received Date

Note : 1. Pl. enclose latest Reference Letter from Ansari Health Centre
2. Original bills/cash-memos. may be submit while claiming the bill with date-wise prescription.

JAMIA MILLIA ISLAMIA
NEW DELHI

DEBIT Medical Component Code PFMS 36.03 ₹
Major Head Other Component

Minor Head Medical Reimbursement Accounts

Amount in Words : Rupees

CREDIT
in favour of
Emp. ID No. (Bank A/C No.)
PFMS U-ID
Indian Bank J.M.I. Branch. Ch. No. Date
Medical Advance Rs. Date of Drawal
TOTAL

F.D.R. No. R/-..... I.L. No..... L.F.No.....

Voucher prepared by dated

Certified that : 1. The balance under the Head of expenditure upto dated is Rs. according to the books of the office before sending the bill under reference.

Financial Authority date : Dy. Registrar/ OSD /Asstt. Registrar date : Registrar date :

Checked by dated

Dealing Assistant dated

Pay by Cash / Cheque ₹ ₹

Transfer / Adjustment ₹

Section Officer Date Accounts Officer Date

Received from the **JAMIA MILLIA ISLAMIA, NEW DELHI-110025** the sum of

₹



Date

Thumb Impression of

Revenue Stamp
Signature

attested



JAMIA MILLIA ISLAMIA

Maulana Mohammed Ali Jauhar Marg

New Delhi-110025

For Retired Emplo

APPLICATION FORM FOR MEDICAL CLAIMS

Application form for reimbursement of medical expenses / treatment of Jamia employees and their family by authorised medical doctors and the hospitals recognised by the Jamia.

1. (a) Name.....
(Name in the block letters)

(b) Designation..... at the time of Retirement.....

(c) Department / Office hant Posted.....

(d) Residential Address

..... Mobile No.....

(e) Family Declaration Register No. R/-.....

(f) If married the place where wife/husband/spouse is employed.....

(g) Department/Office/Salary drawn

2. Basic pension

3. Patient's name and his/her relation to the employee

4. Details of the Amount Claimed:

Medical Attendance :

(a) Name and designation of the medical officer consulted and the hospital / dispensary to which attached

(b) Number and date of consultation and the fee paid for each consultation.....

- (c) Number and dates of injection and the fee paid for each injection
- (d) Whether consultation and/or injections were had at the hospital at the consulting room of the medical officer or at the residence of the patient.....
- (e) Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating.....
- (f) the name of the hospital or laboratory where undertaken.....
- (g) Cost of medicines purchased from the market (enclose Cash Memo and the essential certificate).....

5. Total amount claimed Rs.....

6. List of enclosures.....

Declaration and Certificate to be Signed by the Jamia Employee.

I here by declare that the above statement is true to the best of my knowledge and belief and that person for whom medical expenses were incurred is wholly dependent upon me.

Certified that I(name) Retired
 from(name of the office in which employed)

am not availing of Medical facilities or financial / medical allowance in lieu there of either for myself and / or the spome from any other source (other than under C.S. (M.A.) Rules, 1994.

Dated :

.....
*Signature of the Jamia Retired Employee/
 Family Pensioner*