UNIVERSITY OF DELHI
WUS HEALTH CENTRE (WUSHC)

MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. WUS Health Centers Card No.
_____

2. Validity of WUS Health Centers Card. (For pensioners) from_____to _____

& Entitlement Private / Semi Private/ General

3. Full name of Card Holder (Block Letters)
_____

4. Status (College/University Employee/Pensioner/Temporary/ Permanent

5. The following documents are submitted (Please tick (√) the relevant column)

(a) Medical 2004 Form YES / NO
(b) Photocopy of WUSHC card YES / NO
(c) No. of Original Bills _____
(d) Copy of discharge summary YES / NO
(e) Copy of referral by Specialist /CMO YES / NO
(f) Whether the hospital has given breakup to lab investigation YES / NO
(g) Original papers have been lost the following document are YES / NO Submitted.
l.) Photocopies of claim papers YES / NO
ll.) Affidavit on Stamp Paper YES/ NO
(h) Incase of death of card holder the following documents are submitted

l. Affidavit on Stamp paper by Claimant YES / NO
ll. No objection from other legal Heirs on Stamp papers YES / NO
lll. Copy of death certificate YES / NO

Dated: Signature of WUS Health CentersCardholder/Employee

Telephone No._____ (O)
_____(R)

Name of the Bank _____ Branch _____ SBI A/C NO. _____

Branch MICR Code. _____ Tel. No. of Bank Branch _____

UNIVERSITY OF DELHI

WUS HEALTH CENTRE (WUSHC)

Medical 2004 Form For Reimbursement of Medical Claim

Retirement Medical Form

COMPUTER NO

(To be filled by the claimant)

1. WUS Health Centres Card No.
2. Validity of WUS Health Centres Card.From_____to_____
& entitlement. 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. _____SBI A/C._____
8. Name of the patient & relationship with the card holder_____
9. Status tick ( ) University Employee / Legal Heir / Others
10. Basic Pay/Basic Pension.
11. Name of the Hospital with Address.
    a) OPD Treatment & Investigation.
    b) Indoor Treatment.
12. Date of admission Date of discharge (In case of Indoor Treatment only)
    _____ _____ _____
13. Total amount Claimed
    (a) OPD treatment and Investigations _____
    (b) Indoor Treatment _____
14. Details of Referral _____
Details of Medicals 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 WUS Health Centres beneficiary and the WUS Health Centres card was valid at the time of treatment 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 Health Centres card shall be taken in case of willful suppression of facts or submission of false statements Suitable disciplinary action shall be taken in case of serving employee.

INFORMATION

a) Kindly write correct postal address in block letters.
b) Obtain Break up of investigations from the hospital (detail and rates of individual tests and the exact number of Sugar tests, X-ray films ,etc.) as the reimbursable amount is calculated as per approved rates only.
c) Draft against column (l) of check list – In case of loss of Original Papers.

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Draft for Affidavit for Duplicate Claim Papers/bills on Stamp Paper.

I _____ son/wife/daughter of _____and resident of lost / in placed / not traceable. I herby give an undertaking that I have not received any payment against original bills /claim papers from any source and that if the original papers are traced I shall not slake claim against original bills in future and that in the future and that in the event I receive any cherub against original bills future I shall return the same to competent authority.

Deponent

Verified by Notary Public

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(l) Draft against Column (l) of check list :- In case of Death of card holder.

Draft for Affidavit on stamp Paper for claiming

I _____ wife/son/daughter of late_____and resident of
_____ hereby submit the medical claim papers pertaining to treatment of my father/mother/_____Late Shri / Smt _____ who has
Expired on _____ (copy of Death Certificate is enclosed)

Late Shri/ Smt. _____ has left behind the following other legal on stamp Paper is herewith.

Deponent

Deponent

Verified by Notary Public