MEDICAL CHARGES REIMBURSEMENT FORM

1. Name and Designation : _____

2. Employee Code : _____

3. Branch in which Employed : _____

4. Basic Pay : Rs._____+ Allowance

5. Name of Patient & Relation with the Claimant : _____

6. Period of Illness : _____

7. PARTICULARS OF TREATMENT:

Sr.No	Name of Medicine	Charges (in Rs.)	Details of Cash-Memos etc.
(II) Laboratory Tests/ Ambulance/ Consultancy/ Indoor Room/ Others (Specify)			

8. Total Claim : Rs._____

9. Less- Advance Drawn Vide T/V NO: Dt. Rs. _____

10. Net Amount Payable: Rs. _____

I hereby declare that the statements in this application are true in the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent on me.

(Signature of Claimant)

Date:_____

VERIFICATION CERTIFICATE

I, Dr._____hereby certify that_____Suffering from_____and is/was under my treatment from_____ to_____and the above mentioned medicines/ tests were prescribed by me in this connection. The claim is verified for Rs._____only.

(Signature of Medical Officer)
Designation & Seal.

Countersigned

Passed for Rs. ……..(Rupees)……..……..

and included in Bill No…… Dated: ……

(Signature of DDO)

(Signature of Controlling Officer)

INSTRUCTIONS

1. List all the medicines, tests etc. individually.
2. Attach Cash -Memos duly verified.
3. Mention dates of admission to the Hospital, stay etc.

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