COCOA HEALTH AND EXTENSION DIVISION

MEDICAL CLAIM FORM

NAME OF CLAIMANT:.....STAFF NO. .....

STATION:..... DEPARTMENT:.....

I HEREBY APPLY FOR REFUND OF EXPENSES INCURRED ON .....

REASON.....

.....

AMOUNT (GH¢.....) .....

.....CEDIS .....PESEW

....

DATE SIGNATURE OF CLAIMANT

The above claim is certified correct/not certified correct. The relevant prescriptions/receipts are hereby attached.

....

DATE SUPERVISING HEAD/DISTRICT OFFICER

RECOMMENDED / NOT RECOMMENDED

....

DATE HUMAN RESOURCE MANAGER/HUM. RESOURCE OFFICER

APPROVED/NOT APPROVED

....

DATE DIRECTOR/REGIONAL MANAGER

Claim certified correct. Where rate claim are incorrect the necessary amendments have been made.

....

DATE ACCOUNTS MANAGER/REGIONAL ACCOUNTANT

ACKNOWLEDGEMENT

Day of .....20..... The sum of .....

.....pesewa