

## **MEDICAL EXPENSES REIMBURSEMENT CLAIM**

For the Month/Year of

S.No I		Date	Detail of Expens Prescription Avalible		Tests	Medicine	Self	Amount Claimed  DEPENDENTS  (Specify Relationship)	Total
S.No Ree  1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	Cash Memo/	Date			Tests	Medicine	Self	DEPENDENTS (Specify	
S.No Re	Memo/	Date			Tests	Medicine	Self	DEPENDENTS (Specify	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		Date	Prescription Avalible	Consultancy	Tests	Medicine	Self		Total
2 3 4 5 6 7 8 9 10 11 12 13 14									
2 3 4 5 6 7 8 9 10 11 12 13 14									
3 4 5 6 7 8 9 10 11 12 13 14									
4 5 6 7 8 9 10 11 12 13 14									
5 6 7 8 9 10 11 12 13 14 15									
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20									
TOT	TAL								-
I confirm with the		bove claim	is in respect of myself an	d / or my eligible dep	endants	s is in accor	dance		
					Employees Signature				
			HR DEPARTMENT	USE ONLY					
Entitleme	ent	Rs.							
This clair	im	Rs.		-					
Approved		Rs.		- Approved By HR Dept					
Balance		Rs.							
		HR Of	fficer		Ma	nager HR			
			NANCE DEPARTME	NT USE ONLY					
The ab	bove clain	n of Rs.	has been receiv	red.					
					•	Reci	pient	Signature	