MEDICAL EXPENSES REIMBURSEMENT CLAIM

For the Month/Year of _____

Name of Employee:

Employee #:

Designation:

		Detail of Expenses						Amount Claimed	
S.No	Cash Memo/ Receipt No	Date	Prescription Avalible	Consultancy	Tests	Medicine	Self	DEPENDENTS (Specify Relationship)	Total
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
TOTAL									-

I confirm that the above claim is in respect of myself and / or my eligible dependants is in accordance with the policy.

_____

Employees Signature

HR DEPARTMENT USE ONLY

Entitlement	Rs.		
This claim	Rs.	-	
Approved	Rs.	-	Approved By HR Dept
Balance Left	Rs.		

_____ _____

HR Officer **Manager HR**

FINANCE DEPARTMENT USE ONLY

The above claim of Rs. has been received.

_____

Recipient Signature