MEDICAL CLAIM FORM

Title: _____ Name:_____

Designation: _____

Department: _____

Clinic/Hospital Name : _____

Date of Visit :_____

Symptom: _____

Amount Claim: _____

With Receipt ☐ Without Receipt ☐

Applicants Signature: _____ Date: _____

Manager Remarks:_____

Approved /Not Approved: _____

HR Remarks: _____

Approved /Not Approved: _____

Director's Signature: _____Dated: ___/___/_____