MEDICAL CHARGES REIMBURSEMENT FORM

1. Name and Designation ……..
2. Office in which Employed :……..
3. Basic Pay: ……..
4. Name of Patient & Relation with the Claimant :…….
5. Period of illness :…….
6. PARTICULARS OF TREATMENT :…….

i) **Medicines :-**

S.NO.	**ITEM NAMES** (Medicines names)	**CHARGES**	**DETAILS OF CASH MEMO etc.**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
Total			

ii) **Laboratory Tests/Ambulance/consultancy /Indoor Room/ others :-**

1.			
2.			
3.			
4.			
5.			
TOTAL			

7. Total Claim Rs._____
8. Less Advance Drawn
   Vide T/V No._____
   Dated _____ Rs._____
9. Net Amount Payable Rs._____

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

Dated_____ (Signature of Claimant)

VERIFICATION CERTIFICATE

I Dr. _____ hereby certify that _____ suffering from _____ and is/was under my treatment from _____ to _____ and that the above medicines/tests were prescribed by me in this connection. The claim is verified for Rs. _____.

Dated _____ (Signature of Medical Officer)
Designation & Seal

Passed for Rs._____ (Rupees _____ and included in Bill No. _____ dated _____

BANK ACCOUNT NUMBER **_____** ***BANK NAME*** **_____**

(Signature of controlling officer) **(Signature of DDO)**

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.