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 :

Item Names	*Charges*	*Details of Cash-Memos etc.*
i) Medicines (Names)		
ii) Laboratory Tests/Ambulance/Consultancy/Indoor Room/Others (Specify)		

6. Total Claim Rs._____
7. Less Advance Drawn vide T/V No._____ Dt._____ Rs._____
8. Net Amount Payable Rs._____

I hereby declare that the statements 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.

Date: _____ (Signature of Claimant)

VERIFICATION CERTIFICATE

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

The claim is verified for Rs. _____.

Date: _____ (Signature of Medical Officer)
Designation & Seal

Passed for Rs. _____ (Rupees) _____

and included in Bill No. _____ Dated _____

(Signature of Controlling Officer) (Signature of the 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.