ANNEXURE – D

MEDICAL REIMBURSEMENT CLAIM FORM FOR INDOOR TREATMENT

1. Name of Employee:
2. Designation:
3. Reg. No.:
4. Salary (Basic Pay + DA)/Pension (as on 01-04--------):
5. Place of Duty:
6. Name of Patient:
7. Relationship with Employee:
8. Age:
9. Nature of illness:
10. Name of Doctor/Hospital:
11. Period of treatment: From ---------- To----------
    (Certificate issued by the Medical Officer in-charge of the hospital as per enclosed proforma is to be attached)
12. Details of claim:
    (attach prescription, vouchers, etc. in duplicate)

	Voucher No.	Amount
• Consultation:		
• Diagnostics/Tests:		
• Medicines/Injections:		
• Appliances:		
• Room Rent:		
• Charges for Nurses:		
• Others:		

Total: _____

(Rupees----------)

Declaration:

I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is fully dependent on me.

(Signature of Employee)