H.P.T.R. 6

MEDICAL CHARGES REIMBURSEMENT FORM

1 Name and Designation ………………………………………………………………….

2 Office which Employed ………………………………………………………………….

3 Basic Pay ………………………………………………………………….

4 Name of patient & relation with the claiment. ………………………………………………………………….

5 Period of illness. ………………………………………………………………….

6 ***PARTICULARS OF TREATMENT.***

S.No.	Item Name	Charge	Details of Cash Memos etc.

ii	Laboratory Tests/Ambulance/Consultancy/Indoor Room/Other (Specify)		

7 TOTAL CLAIM Total :- Rs……………………

8 Less Advance Drawn vide
T/Vno………….Dt………. Rs……………………

9 Net Amount Payble. Rs……………………

I bereby declare that the statements in the application are true to the best of my knowledge and belief and that the person for whom medical expanses were incurred is wholly dependent on me.

Date…………………………………. (Signature of Claimant)

VERIFICATION CERTIFICATE

I Dr………………………………………………….hereby certify that …………………………………

is suffering from ……………………………………………………………… and is/was under my treatment

from …………………………to ……………………………and that the above mentioned medicines/tests

Were prescribed by me in this connection.

Claim is verified for Rs. ………………………………

(Signature of Medical Officer)
Designation & Seal.

Date ………………………..

Passed for Rs………………………………(Rs…………………………………………………………………….

and included in the bill no ………………………………. Dated …………………………….

(Signature of Controlling Officer) (Signature of D.D.O.)

INSTRUCTIONS

1. List of the Medicines, tests etc. individually.
2. Attach Cash-Memos duly verified.
3. Mention dates of admission to the Hospital/Stays etc.