$\frac{\textbf{MEDICAL REIMBURSEMENT CLAIM FORM FOR INDOOR}}{\textbf{TREATMENT}}$

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)	
_	XV 1 XV	
	Voucher No. Amount	
•	Consultation:	
•	Diagnostics/Tests:	
•	Medicines/Injections:	
•	Appliances:	
•	Room Rent:	
•	Charges for Nurses:	
•	Others:	
	Total:	
	(Rupees)	
	aration:	
	aration: , hereby declare that the statements given in application are true to the best of my	
I,		is

(Signature of Employee)