APPLICATION FORM FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

1.a.Name of the Employee: _____
(CAPITAL LETTERS)
b.Designation: _____ c.ICNo.:_____ d.Section:_____
e.Unit: _____ f.Ph.No.:_____ g.Basic pay:Rs.___
h.Residential address:_____
i.Whether spouse is also working ? : Yes / No
If yes, Name: Designation:
Pay:Rs. ICNo.: Dept./Unit:

2.a.Name of the patient: _____
b.Age: _____ c.Medical card No.:_____ d.Relationship:____
to employee

3.a.Name of the Hospital/Centre/Lab/ : _____
Specialist and address to which
the patient referred for _____

* b.Referral letter dated : _____
c.Nature of treatment / period : _____

4.a.In case of Chennai beneficiary furnish
Authorised Medical Attendant consulted:_____
b.Registration No. :_____
c.Clinic address :_____
d.Date(s) of consultation :_____

5. If this claim is for reimbursement of expenses like orthopaedic appliances etc., indicate whether any reimbursement obtained earlier ? : Yes / No
If yes, a.Name of the item purchased :

b.Date of purchase: c.Amount reimbursed:Rs.

6. Details of the bill(s) enclosed with the claim:

S.No.	Bill No.	Date	Amount	Particulars

7. Total amount : Rs.
8. Advance drawn, if any : Rs.
9. Advance amount refunded, if any : Rs.
10. Balance amount claimed : Rs.

Date: Signature

(*NOTE: A copy of referral letter is to be enclosed with this claim)

To
CHSS OFFICE, DAE Hospital, Kalpakkam 603 102.