MEDICAL REIMBURSEMENT FORM

EMPLOYEE DETAILS

Employee Type:_____ Employee ID:_____

Name:_____ E-mail:_____

Mobile No._____ Employee Designation:_____

ADDRESS DETAILS

Residential Address:

House No: _____ Street No.:_____ State:_____
District :_____ Village / City / Town:_____

Office Address:

House No: _____ Street No.:_____ State:_____
District :_____ Village / City / Town:_____

EMPLOYEE PAY DETAILS

Pay Source:_____ PRC: _____ State:_____

POSTING DETAILS

HOD Name:_____ DDO Code:_____ Dist._____

TREATMENT DETAILS

Treatment For:_____

Patient Name:_____ Patient Gender:_____

Patient Date of Birth:_____ Age:_____ Relation with Employee:_____

Hospital Name:_____

Hospital State:_____ Hospital District:_____

Date of Admission:_____ Date of Discharge:_____ Total Amount Claimed:_____

Is Hypertensive_____ Is diabetic_____

DECLARATION

I hereby declare that the statement in the application is true to the best of my knowledge and belief & that the person from whom medical expenses were incurred is a member of my family as defined under the Government Servant Medical Attendance Rules 1972 and wholly dependent upon me.

Signature of the DDO

Signature of Employee