MEDICAL REIMBURSEMENT FORM

EMPLOYEE (PENSIONER) DETAILS

Employee Type:______________________________

Employee PPO NO:________________________
Employee I.D.No. :________________________

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 Pensioner:_______________
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 and 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 Pensioner.