Medical Expense Reimbursement Form

Please complete all sections. Attach original medical bills and receipts.

Employee Information

Full Name

Enter your name

Employee ID / Number

Enter employee ID

Department

Enter department

Contact Number

Enter contact number

Patient Information

Patient Name

Enter patient name

Relationship to Employee

Select relationship

Claim Details

Date of Treatment	Name of Hospital/Clinic	Nature of Illness/Treatment	Amount (in $)
	Hospital/Clinic	Treatment	Amount

Total Amount Claimed ($)

Total

Bank Details (for reimbursement)

Bank Name

Bank Name

Account Number

Account Number

IFSC / Branch Code

Branch / IFSC Code

Declaration

I declare that the information provided above is true and the expenses have not been claimed previously.

Employee Signature

Date:
For HR/Accounts Use Only

Date:

Important Notes:

- Attach all original medical bills, prescriptions, and payment receipts.
- Incomplete or incorrect forms may delay reimbursement processing.
- Ensure the claim is submitted within the period as per company policy.
- False claims may result in disciplinary action.
- Consult HR for eligible expenses or any queries before submission.