# Medical Reimbursement Claim Form

## 1. Claimant Details

Employee Name: _____
Employee ID: _____
Department: _____
Contact Number: _____

## 2. Patient Details

Patient Name: _____
Relationship to Employee: _____
Date of Birth: _____

## 3. Hospital Details

Hospital Name: _____
Admission Date: ____/____/_____
Discharge Date: ____/____/_____
Hospital Address: _____

## 4. Treatment Details

Diagnosis: _____
Nature of Treatment: _____
Consulting Doctor: _____

## 5. Expenditure Details

| Description | Bill Number | Date | Amount (INR) |
|---|---|---|---|
| Consultation Fee | _____ | ____/____/_____ | _____ |
| Medicines | _____ | ____/____/_____ | _____ |
| Lab Charges | _____ | ____/____/_____ | _____ |
| Room Rent | _____ | ____/____/_____ | _____ |
| Others | _____ | ____/____/_____ | _____ |
| | | Total Amount Claimed | _____ |

## 6. Declaration

I hereby declare that the information provided above is true and all relevant original bills and documents are attached.

Signature of Employee: _____ Date: ____/____/_____

## Important Notes

- Ensure that all supporting original bills and prescriptions are attached with the claim form.
- Incomplete or incorrect information may result in the rejection or delay of your claim.
- Claim should be submitted within the stipulated time frame as per company policy.
- All details provided must match the supporting documents to avoid discrepancies.
- Cross-check all figures and patient details before submission.