MEDICAL REIMBURSEMENT APPLICATION

1. Applicant Details

Full Name:

Enter your name

Employee/Patient ID:

Enter ID

Department/Designation:

Enter department/designation

Contact Number:

Enter contact number

Email Address:

Enter email address

2. Patient Information

Patient Name:

Enter patient name

Relationship to Applicant:

e.g. Self, Spouse, Child, etc.

Patient Age:

Enter age

3. Treatment Details

Hospital/Clinic Name:

Enter hospital/clinic name

Date(s) of Treatment:

From - To

Nature of Illness/Treatment:

Specify illness or treatment

Attending Doctor:

Doctor's name

Hospitalization Required:

Yes/No

4. Expense Details

Total Medical Bills Amount:

Enter amount (â‚¹)

Amount Claimed:

Enter amount (â‚¹)

Bill Numbers/Documents Attached:

List or count of documents

5. Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge. The bills and documents attached are original and have not been claimed elsewhere.

Date:

Enter date

Signature of Applicant:

Sign here

6. For Office Use Only

Application Received On:

Date of receipt

Verified By:

Name/Signature

Amount Sanctioned:

Enter amount (â‚¹)

Sanctioned By:

Name/Signature

Important Notes

- Fill all sections carefully and attach original supporting documents.
- Bills must be in the applicant or dependent's name.
- Ensure the claim amount does not exceed permissible limits.
- Incomplete applications or missing documents may result in rejection.
- Keep a photocopy of the entire application and enclosures for your record.