Medical Reimbursement Claim Form

1. Personal Information

Name of Employee:

_____

Employee ID:

_____

Department:

_____

Contact Number:

_____

Email Address:

_____

2. Patient Information

Patient Name:

_____

Relationship to Employee:

_____

Age & Gender:

_____

3. Medical Treatment Details

Diagnosis / Reason for Treatment:

_____

Name of Hospital / Clinic:

_____

Date(s) of Admission & Discharge:

_____

Treating Doctorâ€™s Name:

_____

4. Expenditure Statement

Total Bill Amount:

_____

Amount Claimed:

_____

Details of Bills attached (No. & Date):

_____

5. Declaration

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

Date: _____ Signature: _____

6. Office Use Only

Verified By:

_____

Remarks:

_____

Sanctioned Amount:

_____

Authorised Signatory:

_____

Important Notes:

- All details must be filled accurately and legibly.
- Attach original medical bills, prescriptions, and discharge summaries.
- Incomplete or incorrect forms may lead to processing delays or rejection.
- Keep photocopies of all documents submitted for your records.
- Claims must be submitted within the stipulated period as per company policy.