Medical Reimbursement Request

Standard Document Format

1. Applicant Information

Full Name	_____
Employee/Patient ID	_____
Department	_____
Contact Number	_____
Email Address	_____

2. Medical Treatment Details

Patient Name	_____
Relationship to Employee (if applicable)	_____
Date(s) of Treatment	_____
Hospital/Clinic Name	_____
Treating Physician	_____
Diagnosis/Reason for Treatment	_____

3. Reimbursement Details

Bill/Invoice Number	_____
Total Amount Claimed	_____
Bank Name & Account Number (for transfer)	_____
IFSC/SWIFT Code	_____

4. Attached Documents

- Original Medical Bills & Receipts
- Doctor's Prescription
- Discharge Summary (if hospitalized)
- Test Reports/Investigations
- Any Other Relevant Documents

5. Declaration

I hereby declare that the above information is true and the expenses claimed have not been reimbursed from any other source.

Date: _____

Applicant Signature: _____

Important Notes:

- Ensure all bills and documents are genuine and duly signed/stamped by the issuing authority.
- Incomplete forms or missing documents may result in delay or rejection of the reimbursement.
- Retain photocopies of submitted documents for your own records.
- Submission deadlines and reimbursement limits vary as per your organizationâ€™s policy.
- Falsification of information can lead to disciplinary action.