Medical Expense Reimbursement Voucher

Employee Details

Name		**Employee ID**	
Department		**Date of Claim**	

Patient Details

Patient Name		**Relationship**	
Date of Treatment		**Name of Hospital/Clinic**	

Medical Expenses

Description	Bill/Receipt No.	Date	Amount
		Total Amount	

Declaration

I hereby declare that the above information is true and all expenses claimed are as per supporting documents attached. I have not claimed these expenses earlier.

Employee's Signature
Date:

Authorized Signatory
Date:

Important Notes

- Attach original bills, receipts, and prescriptions with this voucher.
- Claims must be submitted within the stipulated period as per company policy.
- Incomplete forms or missing documents may lead to delay or rejection of reimbursement.
- False declaration will attract disciplinary action.
- For any clarification, contact the HR or Accounts department.