Medical Expense Reimbursement Statement

Employee/Claimant Information

Name:

Employee ID:

Department:

Contact Number:

Patient Information

Patient Name:

Relationship to Employee:

Claim Summary

Date of Service	Provider/Hospital	Service/Expense Description	Amount (USD)

Total Amount Claimed:

Bank Details (for Reimbursement)

Account Holder Name:

Bank Name:

Account Number:

IFSC/Swift Code:

Supporting Documents:
Attach original bills, prescriptions, receipts, and reports

Employee Signature

Date: _____

Authorized Signatory
Date: _____

Important Notes

- Submit all original documents with this reimbursement statement.
- Falsification or misrepresentation may result in disciplinary action.
- Ensure each expense is supported by appropriate documentation.
- Reimbursement is subject to your company's medical reimbursement policy.
- Incomplete forms may cause delay or rejection of claim.