Medical Reimbursement Bill

Date of Submission: _____

Employee Name: _____
Employee ID: _____
Department: _____
Designation: _____

Patient Details (if different from employee):
Name: _____
Relationship: _____
Age: _____
Gender: _____

Claim Details

S. No.	Treatment/Expense Type	Bill/Receipt No.	Date	Name of Hospital/Chemist	Amount Claimed (â‚¹)
1	Consultation				
2	Medicines				
3	Diagnostic Tests				
4	Others				
				Total Amount Claimed (â‚¹):	

Bank Details for Reimbursement:
Account Holder Name: _____
Bank Name: _____
Account Number: _____
IFSC Code: _____

Declaration:
I hereby certify that the above expenses have been incurred by me/for my family and are eligible for reimbursement as per company policy. The bills submitted are original and have not been claimed earlier.

Signature of Employee: _____
Date: _____

For Office Use Only

Checked by	Remarks	Approved Amount (â‚¹)	Authorized Signatory

Important Notes:

- Original bills and prescriptions must be attached with this form.
- Ensure all required fields are duly filled to avoid processing delays.
- This form is to be used only for medical expenses covered under company policy.
- False claims may result in disciplinary action as per company rules.
- Retain photocopies of all bills for future reference.