Bill Summary for LTC Reimbursement

Date: **2024-06-11**

Employee Information

Name: **Jane Doe**
Employee ID: **123456**
Department: **Finance**

Patient Details

Patient Name: **John Doe**
Relationship to Employee: **Father**
Patient ID (if applicable): **CD7890**

Bill Details

S. No.	Bill No.	Bill Date	Hospital/Pharmacy	Service/Item	Amount (INR)
1	H56789	2024-05-22	City Hospital	Room Charges	12,000
2	P12034	2024-05-25	Good Health Pharmacy	Medicines	3,450
3	H56790	2024-05-25	City Hospital	Consultation Fee	1,200
				Total	**16,650**

Declaration

I hereby declare that the above expenses have been incurred for the treatment of the patient named above and the original bills are attached for your reference. The claim has not been submitted elsewhere.

Employee Signature: _____
Date: _____

Important Notes

- All bills must be original and duly signed by the employee.
- Bills should not be older than the allowable claim period as per policy.
- Ensure all required documents (prescriptions, discharge summary, etc.) are attached.
- Reimbursement is subject to validation and approval as per LTC norms.