H.P.T.R.6

MEDICAL CHARGES REIMBURSEMENT FORM

1. Name and Designation:
2. Office in Which Employed:
3. Basic Pay:
4. Name of Patient & Relation with the Claimant:
5. Period of Illness:
6. PARTICULARS OF TREATMENT:

Item Names	**Charges**	**Details of Cash-Memos**
ii) Laboratory Tests/Ambulance/Consultancy/Indoor Room/Others(Specify		

7. Total Claim Rs.
8. Less Advance Drawn vide T/V No._____Dt. _____ Rs._____
9. Net:

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred in wholly dependent on me.

Date:

(Signature of the Claimant)

VERIFICATION CERTIFICATE

I Dr. _____ hereby certify that _____ suffering from _____ and is/was under my treatment from _____ to and that the above mentioned medicines/tests were prescribed by me in this connection.

The claim is verified for Rs. _____

Date: _____ **(Signature of Medical Officer)**

Designation & Seal

Passed for Rs. _____ (Rupees) _____ and included in Bill No. _____ Dated: _____.

(Signature of Controlling Officer) **(Signature of the DDO)**

INSTRUCTIONS

1. List all the medicines, tests etc. individually.
2. Attach Cash-Memo duly verified.
3. Mention dates of admission to the Hospital, Stay etc.