

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY SEPERATED NON-Executives

Name & Code: \_\_\_\_\_

Registration of Medical Card: \_\_\_\_\_

Present address at which the Cheque is to be sent: \_\_\_\_\_

1. Name of the Patient: \_\_\_\_\_

2. Relationship with the Retired Executive: \_\_\_\_\_

3. Place at which patient fell ill: \_\_\_\_\_

4. If treatment taken at place other than place of residence, give reasons: \_\_\_\_\_

5. Name of the doctor & hospital: from where treatment taken \_\_\_\_\_

6. Qualification of the Doctor: \_\_\_\_\_

Note:

- 1) Doctor's prescription and cash memos in original should be attached.
2. Receipts of amount claimed should be enclosed.
3. Separate claims should be prepared for each patient and each spell of treatment.

(To be certified by the retired Non Executive)

**I do hereby declare that:**

- i) The statements made in the claim are true to the best of my knowledge and belief.
- ii) I am a member of Contributory Post Retirement Medicare Scheme and my Medical Card is valid since .....
- iii) I continue to fulfill the conditions of eligibility for availing the benefits under the scheme.
- iv) The Medical expenses were incurred for self/spouse.
- v) I fully understand that the Company may refuse/terminate my membership of the scheme at any time without any notice and without assigning any reasons.
- vi) Myself and my spouse are not availing any medical facilities from or through the Central/State Govt./Public Sector undertaking/Quasi Govt. Body either in individual capacity or as dependent.

Date: \_\_\_\_\_

(Signature of the seperated Non-Executive/  
living spouse in case of death)

The claim has been scrutinised and recommended for payment of ₹..... (Rupees.....) only.

Chief of Medical Services

(To be filled by the Accounts Department)

Claim passed for payment of Rupees (in words).....

(in figures) .....

Accountant

Sr. A.O./A.O.

Date:

## (DETAILS OF THE AMOUNT CLAIMED)

		HOSPITALIZATION CASE		AMOUNT	
		₹	P	₹	P.
1. Consultation fees				5. ACCOMMODATION CHARGES FOR THE PERIOD	
Date	Amount			FROM:	
a)				TO:	
b)				₹ ..... per day	
c)					
d)					
TOTAL - 1					
2. INJECTION ADMINISTRATION FEES				6. SURGICAL OPERATION CONFINEMENT CHARGES	
Date	Amount				
a)					
b)					
c)					
d)					
TOTAL - 2					
3. MEDICINES PURCHASED FROM MARKET				7. COST OF MEDICINES	
Date	Amount				
a)					
b)					
c)					
d)					
TOTAL - 3					
A. TOTAL (1+2+3)				C. TOTAL (5+6+7)	
4. PATHOLOGICAL/OTHER TESTS				TOTAL AMOUNT CLAIMED (A+B+C)	
Name of the test	Amount				
a)					
b)					
c)					
d)					
B. TOTAL - 4					

Date:

(Signature of the separated Non-Executive/  
living spouse in case of death)

## DETAILS OF AMOUNT DISALLOWED

Reason

Amount

1

2

3

4

Sr. A.O./A.O.

## CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY SEPERATED NON-Executive FOR out-patient/domiciliary treatment:

Name &amp; Code \_\_\_\_\_

Registration of Medical Card: \_\_\_\_\_

Present address at which the Cheque is to be sent: \_\_\_\_\_

- |   |   |
|---|---|
| 1. Name of the Patient: _____   | Note  |
| 2. Relationship with the Retired Executive: _____                                 | 1) Doctor's prescription and cash memos in original should be attached.             |
| 3. Place at which patient fell ill: _____   |   |
| 4. If treatment taken at place other than place of residence, give reasons: _____ | 2. Receipts of amount claimed should be enclosed.                                   |
| 5. Name of the doctor & hospital: _____<br>from where treatment taken             | 3. Separate claims should be prepared for each patient and each spell of treatment. |
| 6. Qualification of the Doctor: _____   |   |

(To be certified by the retired Executive)

**I do hereby declare that:**

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Date: \_\_\_\_\_

(Signature of the seperated Non-Executive/  
living spouse in case of death)

The claim has been scrutinised and recommended for payment of ₹..... (Rupees.....) only.

Chief of Medical Services

(To be filled by the Accounts Department)

Claim passed for payment of Rupees (in words).....  
(in figures) .....

Accountant

Sr. A.O./A.O.

Date: \_\_\_\_\_