INDIA TRADE PROMOTION ORGANISATION

***

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES

1. Name (in block letters):____
2. Employee Number :____
3. Designation :____
4. Present Basic Pay :____
5. Residential Address :____
6.

Name of Patient	Relationship with Employee	Age (in case of Children
1)		
2)		
3)		
4)		

7. Place at which the patient fell ill : ______________________________________
   (if Sl. No.5 & 7 are different,
   Pl. explain the reason) ______________________________________

8. Name & Address of the Doctor: ______________________________________
   With registration number.

9. Details of amount spent (kindly fill up properly):

	Self	Spouse	Children	Dependant	Total
	Amt. in Rs.	Amt. in Rs.	Amt. in Rs.	Amt. in Rs.	Amt. in Rs.
(A) Tests/investigations (with reports)					
(B) Expenses on Hospitalisation					
Total claims in Rs.					

Total claims (A+B+C) Rs.____________Rupees (in words)____________________

____

Amount of advance, if any Rs. ______________________________________

(i) I hereby declare that the statements made in this claim form are true to the best of my knowledge and belief. The person(s) whose medical expenses was/were incurred is/are member(s) of my family is defined under Rule 3.2.

(ii) Certified that my son(s)/daughter(s) is/are not gainfully employed in Public/Private Sector/Govt. Service.

(iii) My Spouse is not employed in Govt./Public/Private service OR my spouse is employed in Govt./Public/Private Sector and is not claiming/entitled for reimbursement of medical expenses from his/her employer. A certificate to this effect being submitted every year from his/her employer.

(iv) My father and/or mother is/are wholly dependent on me and his/her/their income from all sources does not exceed Rs.4,500/- per month.

\- **Please strike out the declaration not applicable**.

Division: ____________________

Phone/Mobile No. _________________ Date: ___________ (Signature of the Claimant)

Note:

1. Each cash memo, doctor's prescription etc. must be signed by Claimant on backside.
2. Claims for tests etc. submitted to Medical Section will be reimbursed within 10-15 days.
3. In case of hospitalisation claims Income Tax exemption certificate and certificate of prescribed disease (if applicable must be attached with claim form itself otherwise no relaxation for Income Tax purposes will be considered later on.

Certified that hospital is an empanelled hospital and intimation for hospitalization was duly received.

____DM(Administration) _________________

Passed for payment/recovery of Rs.____

Rupees ____ and for adjustment of

Rs.______________________Rupees ____

<table>
<tr><td>Assistant (Accounts)</td><td>Executive (Accounts)</td><td>Dy. Manager (Finance)</td><td>SM(Finance)</td></tr>
<tr><td colspan="2">Tests/Investigations</td><td colspan="2">Hospitalisation</td></tr>
<tr><td>Sl. No.</td><td>Amount in Rs.</td><td>Sl. No.</td><td>Amount in Rs.</td></tr>
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<tr><td></td><td colspan="2" rowspan="6">Summary of amount passed
Hospitalization
____
Tests etc. ______________________________
Total ______________________________________
Less Advance
Deposited
Balance</td><td></td></tr>
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If approved, we may admit the claim for

Rs. _____________________Rupees ____

____

Assistant (Accounts)   Executive (Accounts)   Dy. Manager (Finance)   SM(Finance)

Check List: 1. Match all the bills with prescription, 2. check for family particulars, 3. Number of existing children for delivery cases, 4. Check for disallowed medicines, 5. Check for room rent ceiling, 6. Check for Photostat, carbon copies of money receipt, 7. Check for signature of Claimant on all papers, 8. Check for taxability etc.