एम एम टी सी लि मि टे ड
MMTC LIMITED
भारत सरकार का उपक्रम
A GOVT. OF INDIA ENTERPRISE
touching lives, adding value

CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES

NAME DESIGNATION EMPLOYEE NO. IDENTITY CARD NO. PLACE OF DUTY PAY/LAST PAY DRAWN	RES.ADDRESS TEL.OFF TEL.RES. INTERCOM

NAME OF PATIENT	RELATIONSHIP	AGE	PLACE WHERE PATIENT FELL ILL

NAME OF DISEASE	DURATION OF ILLNESS	NAME OF DOCTOR/ HIS QUALIFICATION

PARTICULARS	AMOUNT CLAIMED (A)	AMOUNT CLAIMED (B)	AMOUNT CLAIMED (C)	AMOUNT ADMITTED(RS)
1. Amount claimed as per certificate A a) Consultation b) Injection charges c) Lab.Test,X-Ray etc. d) Cost of Medicines				
2. Amount claimed as per Certificate B a) Hospitalisation chgs. b) Confinement/operation chgs c) Other Charges d) Cost of Medicines				
Total				

DECLARATION

1. Doctors prescriptions, cash memos, receipts in suppot of the claim should be enclosed in original.
2. I hereby declare that the statements in the claim are true to the best of my knowledge and belief and also declare that the person for whom medical expenses were incurred is wholly dependent on me. He/She normally residing with me.

Place:
Date: Signature of the claimant

For official use only

Date_____

Passed for Rs._____

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ASSISTANT OM(A/CS)/SR.OM MANAGER(F&A)