CENTRAL POWER RESEARCH INSTITUTE, BANGALORE

Employee /Pensioner

Form of Application for Claiming Reimbursement of Medical Expenses towards OutPatient / treatment			
1.	Name & Designation	:	
2.	Division	:	
3.	Basic Pay & Grade Pay , Initial Pension (in case of pensioners)	:	
4	Status (Employee/Pensioner/ Family pensioner)	:	
5.	Full Address with Phone No.	:	
6.	If married where the wife/husband is employed	:	
7.	Name of the Bank, Branch & Account No. where reimbursement has to be credited.	:	
8.	Name of the patient and relationship with Employee / pensioner	:	
9.	Place at which the patient fell ill	:	
10.	Nature of disease		
11.	Period of treatment	:	.....से / From..... तक / To (.....days ..... months)

12. Details of amount claimed and fees for consultation indicating :

	Name & Designation of the Medical Officer and Hospital	No. and date of consultations & fee paid for each consultation	Whether consultation / injection had at the consulting room or at the residence of the patient.

13. Charges for Pathology/ Bacteriology / Radiology or any other similar tests undertaken during diagnosis.

	Name of the hospital/ lab. where tests were undertaken	Name of the test/s	Charges for the test/s	Whether the tests were under -taken on the advice of the Doctor / AMA
			Total Rs.	

14	Name of the medicine/s prescribed by the Doctor, No. of medicines purchased and cost of the medicine (cash memos to be enclosed)		
	Name of the medicine/s prescribed	No. of medicine/s purchased	Cost of the Medicine
15	Consultation with specialist, fees paid a specialist or Medical Officer indicating :		
	Name & designation of the specialist / Medical officer consulted and Hospital to which he attached to .	No. & dates of consultations and fee paid for each consultation .	Where the consultation was had i.e., at the hospital, consulting room of the specialist /medical officer , at the residence .
16.	Total amount claimed	Rs.	
17.	List of enclosures	a. Prescription b. Cash memo c. Cartons	

DECLARATION TO BE SIGNED BY THE EMPLOYEE

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

Date Signature of the Employee

/Office Use

Bill checked and passed for payment of Rs. / - (Rupees only)

प्रभागीय प्रधान
Head of the Division