

IISER BHOPAL
(MEDICAL BILL REIMBURSEMENT FORM)

1. Name and Designation : _____

2. Department : _____

3. PF. No. : _____

4. Basic Pay : _____

5. Name of Patient & relation with the Claimant : _____

Sl. No.	Name of the Medicines	Qty.	Details of Cash-Memos	Amount
Testing Charges/Consultancy/Other (Specify)			Details of Cash-Memos etc.	Amount
TOTAL :				

6. Total Claim Rs.....
7. Less – Advance Rs.....
8. Net Amount Payable Rs.....

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 is wholly dependent on me.

Date

Signature of the Claimant

(2)

VERIFICATION CERTIFICATE

I, **Dr. ANIL BATRA** hereby certify that Patient Name.....
F/o / S/o / D/o / W/o / H/osuffering from.....
and is / was under my treatment from.....to.....and that the above
mentioned medicines/test were prescribed by me / referred Dr.
in this connection. This claim is verified for Rs.....

Date.....

(Signature of Medical Officer)
Designation & Seal

Passed for payment of Rs..... (Rupees.....)
and included in Bill Nos..... Dated.....

Dealing Asstt.

Registrar

Pay Rs. _____

Finance Officer

INSTRUCTIONS

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