# INDIAN INSTITUTE OF SCIENCE, BANGALORE

C. Bill No.....

CONSOLIDATED CLAIM FORM FOR MEDICAL REIMBURSEMENT FOR THE MONTH OF .....200

(To be submitted by the employees / pensioners between 1st and 15th of every month)

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Name of the employee / Pensioner | | | | | | | Employee / Pensioner Code | | | | | | | |
| 2 | Designation ( Incase of employee) | | | | | | | Dept. (Incase of employee) | | | | | | | |
| 3 | Bank A/c No. | | | | | | | Name of the Bank | | | | | | | |
| Sl. No. | Name of the Patient | Relationship to the employee / Pensioner | CMO/ MO/ AMO consulted | Period of treatment | | Amount claimed Rs. | | | | Amount Admitted Rs. **For Office use** | | | | | |
| | | | | From | To | Med. | Lab. | Cons. | Total | Med. | Lab. | Cons. | Total | | |
| 1. | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | | |
| 5. | | | | | | | | | | | | | | | |
| 6. | | | | | | | | | | | | | | | |
| 7. | | | | | | | | | | | | | | | |
| **Grand Total** | | | | | | | | | | | | | | | |

It is certified that individual that claims indicated above have been certified by the CMO / MO/AMO concerned and the relevant prescriptions, Cash Memos for purchase of Medicines and Referral & Receipts for Lab Test, etc., have been enclosed.

Signature of the Employee/ Pensioner

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**For Office use**

**Passed for Rs.....(Rupees.....only)**

# INDIAN INSTITUTE OF SCIENCE, BANGALORE 560 012
# CONTRIBUTORY HEALTH SERVICE SCHEME

## Application for claiming reimbursement of Medical Expenses

(Separate form should be used for each patient)

1. Name (in Block letters).....

2. Designation.....Department.....

3. CHSS No. .....Bank Account No. .....Bank.....

4. Name of the Patient.....Relationship.....Employed/Not Employed

[(1) If the spouse is employed, state whether or not he/she avails of medical reimbursement from his/her employer/organisation (2) In the case of children state the age)]

5. Name of the Medical Officer/Area Medical Officer/Specialist.....

6. No. and date of consultation.....

7. Name of the Nursing Home/Hospital/Clinic.....

8. Period of Treatment From..... To.....

9. Particulars of Claim : (Prescriptions and Cash Memos should be attached)

**MEDICINES**

| Sl. No. | Description of Medicines | Qty. | Amount | Sl. No. | Description of Medicines | Qty. | Amount |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | TOTAL | | | | TOTAL | | |

**INVESTIGATIONS**

| Sl. No. | Details of Investigations | Amount |
|---|---|---|
| | | |
| | TOTAL | |

**CONSULTATIONS/OTHERS**

| Sl. No. | Details | Amount |
|---|---|---|
| | | |
| | TOTAL | |

**Total amount claimed Rs.** .....

I hereby declare that the statements made are true to the best of my knowledge and belief and that the person for whom the medical expenses were incurred, is wholly dependent upon me and his/her total income does not exceed Rs. 1,500/- per month.

Date :

*Signature of Staff Member*

**ESSENTIALITY CERTIFICATE**

I certify that the medicines and tests indicated in the claim were prescribed by me and were essential for his/her recovery/prevention of serious deterioration in the condition.

Date :

*CMO / MO / AMO*

**FOR OFFICE USE ONLY**

Claim verified and also the list of inadmissible items. Claim bill admitted and passed for Rs. .....

Rupees.....only)

*Case Worker* *Superintendent* *Accounts Officer* *Internal Auditor*