



INDIAN INSTITUTE OF SCIENCE, BANGALORE - 560012
CONTRIBUTORY HEALTH SERVICE SCHEME

Application for claiming reimbursement of Medical Expenses
 (Separate form should be used for each patient)

- Name (In Block Letter)Age.....
- Designation.....Department.....
- Med Diary No.....Bank Account No.....Bank.....
- Name of the patient.....Relationship.....Employed / Not Employed Age.....
 [(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 ()]
- Name of the Medical officer / Area Medical officer / Specialist
- No. And date of Consultation
- Name of the Nursing Home / Hospital / Clinic
- Period of Treatment From to.....
- Particulars of Claim : (Prescription and Cash Memos should be attached)

MEDICINE

SL No	Description of Medicines	Qty	Amount	SL NO	Description of Medicines	Qty	Amount
			Total				Total

INVESTIGATIONS

CONSULTATIONS / OTHERS

SL No	Description of investigations	Amount	SL NO	Description of Investigations	Amount	
			Total			

Total amount claimed Rs.....

I here by Declare that the statements made are true of 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 the Staff Member _____

ESSENTIALITY CERTIFICATE

I here by Declare 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 : _____ Signature of the Staff Member _____

For Office use only

Claim verified and also the list of inadmissible item. Claim bills admitted and passed for Rs..... (Rupees.....only)

Case worker

Superintendent

Account officer

Internal Auditor