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INDIAN INSTITUTE OF SCIENCE, BANGALORE - 560012

[Application for reimbursement of Medical Expenses (Out patient)]

RETIRED EMPLOYEE

CHSS No. **P.P.O. No. :**

Name of the Bank & Account No.....
Name of the Member .....Phone No.....
Name of the Patient .....Age.....
Relationship to Member .....Employed / Not Employed Referred by Dr.....

Period of claim From.....To.....

MEDICINES

SL No	Name	Qty	Amount	SL NO	Name	Qty	Amount
		Total				**Total**	

INVESTIGATIONS AND OTHERS

SL No	Details	Amount	SL NO	Details		Amount
	Total				**Total**	

(Prescription and Cash Memos are to be enclosed) Total amount claimed Rs.....
* I am not a beneficiary of any other medical reimbursement scheme.
* The patient is wholly dependent on me and his/her income does not exceed Rs. 1,500/- p.m.

Date : Signature of member

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

CMO / MO / AMO

FOR OFFICE USE

Checked
Claim passed for Rs.....(Rs.....)

Case Worker Superintendent Internal Auditor Accounts Officer