C. BILL No._____  INDIAN INSTITUTE OF SCIENCE, BANGALORE

CONSOLIDATED CLAIM FORM FOR MEDICAL REIMBURSEMENT FOR THE MONTH OF _____

(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 (in case of employee)						Dept. (in case of employee)						
3.	Bank A/c No						Name of the Bank						
SL NO	Name of the Patient	Relation-ship to employee / Pensioner	CMO / MO / AMO consulted	Period of treatment		Amount claimed Rs.				Amount Admitted Rs.			
				From	To	Med.	Lab.	Cons.	Total	Med	Lab.	Cons.	Total
1.													
2.													
3.													
4.													
5.													
6.													
7.													
Grand Total													

It is certified that individual 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

Passed for Rs._____(Rupees_____only)

Case Worker Supervisor / Supdt. MEDICAL OFFICER