REGIONAL CENTRE FOR BIOTECHNOLOGY

(NCR BSC, Faridabad-Gurgaon Expressway, Faridabad)

S.B .A/c	No
Telephon	e No

FORM OF APPLICATION FOR MEDICAL CLAIM

1.	Name (in block letter s)	: Dr./Sh./ Ms			
2.	Designation	:			
3.	Office in which employed	:			
	(RCB/Project)				
4.	Basic Pay	:			
5.	Residential Address	:			
6. Name of the patients and his/her					
	relationship with the Govt. Servant	:			
7.	Place of Duty	:			
8.	Nature of illness and its duration	:			
9.	Details of the amount claimed	:			
	(Medical attendance)				
	(a) Name and designation of the Medical	:			
	Officer constituted and the Hospital/				
	Dispensary to which attached				
	(b) The number and dates of consultation	:			
	and the fee paid for each consultation				
	-	:			
	had at the hospital or at the Consultation	n			
	Room of the Medical Officer or at the				
	residence of the patient				
	•	:			
	the fee paid for each injection including				
	fees/charges paid for clinical tests				
	~ ~	: Rs9(a) to (e)			
	purchased from the market	()			
10.	Total amount claimed				
	List of enclosures				
•					

DECLARATION TO BE SIGNED BY THE EMPLOYEE

I hereby declare that the statements in the application form are true to the best of my knowledge and belief and the person/persons from whom medical expenses were incurred is/are wholly dependent upon me.

Date:	(Signature of the Employee)

MEDICAL REIMBURSEMENT CLAIM

	12. Det	12. Details of medical reimbursement claim in respect of Dr./Shri/Smt						
Rupees	workin	g as		fo	or the month of			
Grand Total (Col. 10 + 12) DECLARATION 1. I certify that the patient (s) for whom medical reimbursement claim has been made in the bill is/are wholly dependent upon me. 2. I certify that my wife/husband is not employed in Government/ semi Government service and he/she has not submitted any claim. 3. I certify that the Super Bazar or any other co-operative drug store is not within two kilometres of my residence. Accepted and Countersigned Signature of the claimant Date		patient and	drug store/	Memo No.	Medicine (s)	of each	Total of each cash memo	
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Accepted and Countersigned Signature of the claimant Date		•		employed in	Government/ s	semi Governme	ent service	
Date			-	ny other co-	operative drug	store is not v	within two	
	Accept	ed and Countersig	gned		Sig	gnature of the c	laimant	
Claim passed for Rs(Rs.				Date				
	Claim _I	passed for Rs		(Rs)	

Asstt. Sr. Manager