

C. Bill No.....

INDIAN INSTITUTE OF SCIENCE, BANGALORE

CONSOLIDATED CLAIM FORM FOR MEDICAL REIMBURSEMENT OF THE MONTH OF 201
(To be submitted by the employees / pensioners between 1st and 15th of ever 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									
4 Phone No./ Mobile No. Employee / Pensioner													
Sl. No.	Name of the Patient	Relationship to the Employee / Pensioner	CMO/ MO/ AMO Consulted.	Period of treatment		Amount claimed Rs.				Amount Admitted Rs.			
				From	To	Med.	Lab.	Cons.	Total	For Office use			
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

For Office use

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

Case Worker

Supervisor / Supdt.

MEDICAL OFFICER