MEDICAL REIMBURSEMENT CLAIM FORM
FOR INDOOR TREATMENT (BSNL)

1. Name of Employee:
2. Designation:
3. Reg.No:
4. Salary (Basic Pay + D.A)/Pension (as on 1.04.04):
5. Place of Duty:
6. Name of the Patient:
7. Relationship with Employee:
8. Age:
9. Nature of illness:
10. Name of Doctor/Hospital:
11. Period of Treatment: From_________ To _______________
    (Certificate issued by the Medical Officer in-charge of the Hospital as per enclosed proforma is to be attached)
12. Details of claim:
    (attach prescription, vouchers, etc., in duplicate)

	Voucher No.:	Amount Rs.:
• Consultation:		
• Diagnostics/Tests:		
• Medicines/Injections:		
• Appliances:		
• Room Rent:		
• Charges for Nurses:		
• Others:		
	Total:	

(Rupees__________________________________)

Declaration:
I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for whom medical expenses are incurred is fully dependent on me.

(Signature of Employee)