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MEDICAL REIMBURSEMENT CLAIM BILL

Detail of medical rre-imbursement claim charges in r/o …..... Working as …..... in …..... for the month of …..... .....

Sr. No.	Cash Memo No.	DATE	NAME OF PATIENT AND RELATIONSHI	MEDICINE	AMT. OF EACH MEDICINE	TOTAL OF EACH CASH MEMO	NAME OF DRUG STORE/ CHEMIST
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
				TOTAL			

Rs. in Words.....

1. I certified that the patient for whom the medical re-imbursement claim has been made in the bills is/are wholly depends upon me.
2. I certified that my wife/husband is not employed in Govt./Semi Govt. services and he/she has not submitted any claim for the purpose.
3. I certified that Super Bazar or any other co-operative drug store is not less than 2 km. for away from my residence.

Accepted and countersigned

Signature of Claimant

Signature of Principal with Stamp

Date / / 20.....

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