



A Maharatna Company

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY THE RETIRED EXECUTIVE

Name of Retired Executive :

Code (Employee No. / EIS No.) :

Registration of CPRMSE Medical Card No. : CPRMSE /.....

Present address with Pin Code :

at which Cheque is to be sent _____

Bank Name : & A/C No.

1	Name of the Patient	:	
2	Relationship with the retired executive	:	
3	Place at which patient fell ill	:	
4	If treatment taken at place rather than place of residence, give reasons	:	
5	Name of the doctor & hospital from where treatment	:	
6	Qualification of the Doctor	:	

- Note: 1) Doctor's prescription and cash memos in original should be attached.
 2) Receipts of amount claimed should be enclosed in ORIGINAL
 3) Separate claims should be prepared for each patient and each spell of treatment.

I hereby declare that :

- i) The statements made in the claim are true to the best of my knowledge and belief.
- ii) I am a member of Contributory Scheme for Post Retirement Medical Facilities and my Medical Card is **valid since _____ Life time.**
- iii) I continue to fulfill the conditions of eligibility for availing the benefits under the scheme.
- iv) The Medical expenses were incurred for self/spouse.
- v) I fully understand that the Company may refuse/terminate my membership of the scheme at any time without any notice and without assigning any reasons.
- vi) Myself and my spouse are not availing any medical facilities from or through the Central/State Govt/Public Sector Undertaking/Quasi Govt. Body either in individual capacity or as dependent.

Date:

(Signature of the retired executive/
living spouse in case of death of retired executive)

The claim has been scrutinized and recommended for payment of Rs. _____ (Rupees _____) only

Chief of Medical Services

(To be filled in by the Accounts Department)

Claim passed for payment of Rupees (in words) _____
(in figures) _____

Accountant

Sr. A.O./A.O.

Dated:



A Maharatna Company

Annexure-B/3

DETAILS OF THE AMOUNT CLAIMED

	AMOUNT		HOSPITALIZATION CASE	AMOUNT	
	Rs	P		Rs	P
1. CONSULTATION FEES Date Amount a) b) c) d) TOTAL 1.			5. ACCOMODATION CHARGES FOR THE PERIOD FROM TO : @Rs..... per day		
2. INJECTION ADMINISTRATION FEES Date Amount a) b) c) d) TOTAL 2.			6. SURGICAL OPERATION OR CONFINEMENT CHARGES		
3. MEDICINES PURCHASED FROM MARKET Date Amount a) b) c) d) TOTAL 3.			7. COST OF MEDICINES		
A. TOTAL (1+2+3)			C. TOTAL (5+6+7)		
4. PATHOLOGICAL AND OTHER TESTS Name of the test Amount a) b) c) d) B. TOTAL 4.			TOTAL AMOUNT CLAIMED (A + B + C) In figures - In words :-		
Date:			(Signature of the retired executive/living spouse in case of death of retired executive)		
DETAILS OF AMOUNT DISALLOWED					
Reason:			Amount :		
1					
2					
3					