Medical Form No. 26 (Revised)

Financial Year : 20……..

SHRI LAL BAHADUR SHASTRI RASHTRIYA SANSKRIT VIDYAPEETHA

B-4, QUTUB INSTITUTIONAL AREA, NEW DELHI-16

Total No. of Enclosures : ……..

Date of Submission: ……

MEDICAL BILL PROFORMA

(Reimbursement of Medical Expenses)

1. Name of the Employee : ……
2. Designation : ……
3. Pay Matrix : *BASIC PAY* …… *LEVEL* ……..
4. Whether Empanelled Hospital (Yes/No) : *YES* [ ] *NO* [ ]
5. Treatment Taken (OPD/In-patient) : *OPD* [ ] *In-Patient* [ ]
6. Essentiality Certificate(A/B) enclosed : *Certificate **'A'*** [ ] *Certificate **'B'*** [ ]
7. Details of the Expenditure incurred :

A. ***Personal/Family Details:-***

S.NO	PATIENT NAME	AGE	RELATIONSHIP	DOCTOR NAME	Hospital/Dispensary
1					
2					
3					
4					

B. ***Charges Details @ CGHS RATE :-***

SNO	CONSULTATION -(1)		MEDICINE-(2)		TEST LABORATORY- (3)		TOTAL AMOUNT (1+2+3)
	Date	*Amount*	*Date*	*Amount*	*Date*	*Amount*	
1							
2							
3							
4							
Total Amount of Bill Claimed (Rs.)							

DECLARATION

I hereby declare that the statements in the application are true to the best of my knowledge and the person(s) for whom medical expenses were incurred is wholly dependent upon me.

Signature of Employee

(FOR OFFICE USE ONLY)

Total Amount Claimed : …… Amount Not Admissible : ……

Amount Admissible/Passed : …… Less Advance taken : ……

The Total Admissible/Passed amount of Rs …… payable to employee incurred on Medical treatment(s) may be reimbursed to Shri/Smt/Dr./Prof……on dated : ……

DEALING ASSISTANT **S.O.(ADMN)** **A.R.(ADMIN)**