INDIAN INSTITUTE OF SCIENCE, BANGALORE 560 012
CONTRIBUTORY HEALTH SERVICE SCHEME

Application for claiming reimbursement of Medical Expenses

(Separate form should be used for each patient)

1. Name (in Block Letter).....
2. Designation.....Department.....
3. CHSS No.....Bank Account No..... Bank.....
4. Name of the Patient..... Relationship .....Employed / Not Employed

   [(1) if the spouse is employed, state whether or not he/she avails of medical reimbursement from his/her employer / organisation (2) In the case of children state the age)]
5. Name of the Medical Officer / Area Medical Officer / Specialist
6. No. and date of Consultation
7. Name of the Nursing Home / Hospital / Clinic
8. Period of Treatment From To
9. Particulars of Claim : (Prescription and Cash Memos should be attached)

MEDICINE

Sl. No.	Description of Medicines	Qty.	Amount	Sl. No.	Description of Medicines	Qty.	Amount
		TOTAL				TOTAL	

INVESTIGATIONS

Sl. No.	Description of Investigations	Amount
	TOTAL	

CONSULTATIONS / OTHERS

Sl. No.	Details	Amount
	TOTAL	

Total amount claimed Rs.....

I hereby declare that the statements made are true to the best of my knowledge and belief and that the person for whom the medical expenses were incurred, is wholly dependent upon me and his/her total income does not exceed Rs. 1,500/- per month.

Date : *Signature of Staff Members*

ESSENTIALITY CERTIFICATE

I certify that the medicines and tests indicated in the claim were prescribed by me and were essential for his/her recovery/ prevention of serious deterioration in the condition.

Date : *CMO / MO / AMO*

FOR OFFICE USE ONLY

Claim verified and also the list of inadmissible items. Claim bills admitted and passed for Rs.....
(Rupees.....only)

Case Worker Superintendent Accounts Officer Internal Auditor