INDIAN INSTITUTE OF SCIENCE, BANGALORE

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CONSOLIDATED CLAIM FORM FOR MEDICAL REIMBURSEMENT FOR THE MONTH OF (To be submitted by the employees / pensioners between 1st and 15th of every month)

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	7.	6.	5.	4.	ω	2.	1.		SI. No.		ယ	2	->																									
Grand Total						-		Name of the Patient			Bank A/c No.	Designation (Incase of employee)	Name of the employee / Pensioner																									
								Pensioner	to the	Relationship		oloyee)	nsioner																									
								COLLEGIEC	CMO/ MO/ AMO consulted																													
								From	treatment	treati	Period of																											
								То	nent	d of																												
					2			Med.						Amount claimed Rs.																								
								Lab.	Amount c						Amount claimed Rs.																		Amount cl	Amount cl	Amount cl	Amount cl	Amount c	Amount cl
												Cons.	aimed Rs.			limed Rs.		limed Rs.		imed Rs.		Name of the Bank	Dept. (Incas	Employee / Pensioner Code														
								Total																								Total			Dept. (Incase of employee)	Pensioner C		
								Med.	For Office use	Amount		e)	ode																									
								Lab.																														
								Cons.		Amount Admitted Rs																												
								Total									S.																					

It is certified that individual that claims indicated above have been certified by the CMO / MO/AMO concerned and the relevant prescriptions, Cash Memos for purchase of Medicines and Referral & Receipts for Lab Test, etc., have been enclosed.

Signature of the Employee/ Pensioner

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For Office use

Case Worker

Supervisor / Supdt.

MEDICAL OFFICER