Name of the Bank & Account No ………………………………………………………………………………………………………………………………………………

Name of the Member ………………………………………………………………………….Phone No…………….……………………………………..

Name of the Patient ………………………………………………………………………………………Age…………………………………………………

Relationship to Member ………..……Employed / Not Employed Referred by Health Center Dr………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| **Sl. No.** | **Description of Medicine** | **Qty.** | **Amount** |
| **1****2****3****4****5****6** |  |  |  |
| **TOTAL** |  |

Period of Claim From .………………………………..…………………………… To …………………………………………………………………

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl.****No.** | **Description of Investigations** | **Amount** | **Sl.****No.** | **Description of Consultation/Others** | **Amount** |
| **1****2****3****4****5** |  |  | **1****2****3****4****5** |  |  |
| **TOTAL** |  | **TOTAL** |  |

(Prescription and Cash Memos are to be enclosed) Total amount claimed Rs………………………………………………………………. (Rupees…………………………………………………………………………………………………………………………………………………………………………….)

\*I am not a beneficiary of any other medical reimbursement scheme.

\*The patient is wholly dependent on me and his/her income does not exceed Rs. 9000+DA p.m.

**Date: Signature of Member**

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**

Checked

Claim passed for Rs……………………………….(Rs…………………………………………………………………………………..……………………………………)

Case Worker Superintendent Accounts Officer Internal Auditor