

C. Bill No. \_\_\_\_\_

## INDIAN INSTITUTE OF SCIENCE, BANGALORE

CONSOLIDATED CLAIM FORM FOR MEDICAL REIMBURSEMENT FOR THE MONTH OF \_\_\_\_\_ 200  
(To be submitted by the employees / pensioners between 1<sup>st</sup> and 15<sup>th</sup> of every month)

1	Name of the employee / Pensioner					Employee / Pensioner Code							
2	Designation ( in case of employee)					Dept. ( in case of employee)							
3	Bank A/c No.					Name of the Bank							
Sl No	Name of the patient	Relation ship to employee/ Pensioner	CMO / MO/AMO consulted	Period of treatment		Amount claimed Rs.				Amount Admitted Rs.			
				From	To	Med.	Lab.	Cons.	Total	Med.	Lab.	Cons.	Total
1													
2													
3													
4													
5													
6													
7													
Grand Total													

It is certified that individual 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. Tests, etc., have been enclosed.

\_\_\_\_\_  
Signature of the Employee/Pensioner

Passed for Rs. \_\_\_\_\_ (Rupees \_\_\_\_\_ only)

Case Worker

Supervisor / Supdt.

MEDICAL OFFICER

## INDIAN INSTITUTE OF SCIENCE

(To be submitted by the employees / pensioners in every April/July/October/January for claims pertaining to previous quarter)

It is certified that individual claims indicated above have been certified by the CMO/ MO/AMO concerned and the relevant Prescriptions and Cash Memos for purchase of Medicines and Lab. Tests have been enclosed.

Signature of the Employee