

APPLICATION FORM FOR CLAIMING REFUND OF MEDICAL EXPENSES

1. Name of the Govt. Servant : _____
2. Designation : _____
3. Office in which employed and place of duty : _____
4. Pay Scale of Govt. Servant : _____
5. Residential Address : _____
: _____
6. Name of the patient and his/her relationship to the Govt. Servant

7. Name and designation of the Medical Officer consulted and the name of Hospital/Dispensary to which attached _____
8. Detailed of the amount claimed:
 - a. For Laboratory X-Ray and other similar test under taken

 - b. Cost of medicine purchased from the market

S.NO.	NAME OF THE MEDICINE	PRICE	S.NO.	NAME OF THE MEDICINE	PRICE
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I hereby declare that the statement in this application is true to the best of my knowledge and belief and that person for whom medical expenses were incurred is wholly dependent.

SIGNATURE OF THE GOVT. SERVANT

Enclosure:-

(1) Essentiality Certificate (2) Cash memos (3) Prescriptions

Note: In column No.8(1) please indicate (i) The name of the Hospital or Laboratory where the test were undertaken and (ii) whether the tests were undertaken on the advice of the authorized medical attendant, if so, a certificate to the effect should be attached.