

FORM-B2

Satluj Jal Vidyut Nigam Limited		CLAIM FOR MEDICAL REIMEURSEMENT HOSPITALISATION			Mode of Payment: Cash/Bank Place of Payment:			
DIARY NO.								
Date received		CC		VR-No.		VR-DATE		SC NA
Project	Deptt.	Name of Employee			Claim Date	Emp.No.	Rs. Claim Amount	
Employee's Name				Designation				
Basic Pay				Deptt		Rax No.		
Bank Name				Bank Account No.				

Claim passed for payment for Rupees (in words).....

Account Code	Amount	Cash/Bank	Code	Mode	Cheque No.

Received Rs. Rupees(in words)
.....

NOTE :

Sign. of the Employee
Date:

1. Doctor's prescription & cash memos in original should be attached in all cases.
2. Receipts for the amounts claimed should be enclosed.

SL.NO. 1 TO 5 BE FILLED BY THE EMPLOYEE
(To be detached and sent back to the employee by Accounts Deptt.)

1. Name
2. Employee No.....
3. Deptt.
4. Claim Date.....
5. for Rs.
6. Passed for Rs. and credited to bank on

(For deduction see overleaf)

DETAIL OF AMOUNT CLAIMED							
HOSPITALISATION CASES				Amount In Rs. P.			
Patient's Name & Relation	Name of Hospital	From Date	To Date	Rate/day Rs. P.	Amount Rs. P. 5	Cost of Medicine Rs. P. 6	Surgical OP/ Confinement Charges 7
Total 5+6+7 in Rs.							
Less Amount of advance Rupees					Rs. In Words		
Net Amount Claimed Rs.							

Certified that the particulars mentioned in this claim are true to the best of my knowledge and belief and that the person to whom medical expenses were incurred is wholly dependent upon me and residing with me.

Signature of employee

Signature of the Controlling

Date

officer with designation & stamp

DETAIL OF AMOUNT DISALLOWED

Reasons

Amount

- 1.
- 2.
- 3.
- 4.

A.O./Sr. A.O.