

FORM-D

**CONTRIBUTORY SCHEME FOR POST RETIREMENT MEDICAL FACILITIES
CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED
BY THE RETIRED EMPLOYEE**

Name & Grade of the retired employee	Employee No.	Last Pay Drawn	Medical Card Number
			Medical Card valid upto
Present Address at which the Cheque is to be sent.			

1. Name of the patient
2. Relationship with the retired employee
3. Place at which patient fell ill
4. If treatment taken at place other than the place of residence, give reasons
5. Name of the doctor or Hospital from where treatment taken
6. Qualification of the doctor

Note:

- 1) Doctor's prescription and cash memos in original should be attached.
- 2) Receipts for amounts claimed should be enclosed.
- 3) Separate claim should be prepared for each patient and each spell of treatment.

(To be certified by the retired employee)

I hereby declare that:

- i) The statements made in the claim are true to the best of my knowledge and belief.
- ii) I am a member of Contributory Scheme for Post Retirement Medical Facilities and my medical card is valid upto
- iii) I continue to fulfill the conditions of eligibility for availing the benefits under the scheme. iv) The medical expenses were incurred for self/spouse.
- v) I fully understand that the Company may refuse/terminate my membership of the Scheme at any time without any notice and without assigning any reason.

Date:

Signature of the retired employee/
in case of death, spouse may sign.

(To be filled in by the Accounts Department)

Claim passed for payment Rupees (in words)
(In figures)Dated:

Accountant

Sr. AO/ AO

Received rupees (in figures)(in words)

Dated:

Signature of the retired employee

DETAILS OF THE AMOUNT CLAIMED

Non-hospitalisation case	Amount Rs. P	Hospitalisation case	Amount Rs. P.
1. Consultation Fee a) b) c) Total 1		5. Accommodation charges for the for the period From To @ Rs. Per day	
2. Injection Administration Fees Date Amount a) b) c) Total 2		6. Surgical Operation or Confinement charges 7. Cost of Medicines C. Total (5+6+7) Total amount claimed (A+B+C) Less: Amount of Advance Net Amount Claimed	
3. Medicines purchased from market C.M. No. Amount a) b) c) d) e) Total 3			
A. Total (1+2+3)			
4. Pathological/Other Tests (Name of the test) Amt. a) b) c) d) B. Total 4			

Date:

Signature of the retired employee

Details of Amount Disallowed

Reasons

Amount

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

AO/Sr.A.O.