RASHTRIYA CHEMICALS & FERTILIZERS LIMITED
Application for Medical Reimbursement

(To be submitted **within three months** from initiation of the given spell of treatment)

Hospital Inward
No.:
Date:

Tick in the applicable box:

On Roll	Retired	VRS	Expired	Date	Contributory	Non-Contributory

Name of Employee : _____ Cost Code : _____ Tkt No. : _____

Deptt. : _____ Designation: _____ Basic Pay Rs. _____

Place of Posting : _____ Tel. No. Int. : _____ Ext : _____

Mobile No. : _____ e-mail ID : _____

Name of the Patient : _____ Age : ___ Relationship : _____Patient's ID : _____

Residential Address of Employee : _____

_____

Patient's address (if not staying with employee):_____

_____

Illness / complaints : _____

Period of treatment : From: _____ To : _____ Total Claimed Amount : Rs. :_____

Medical advance : Yes :____ No : ____ If yes : Rs. : _____ Date : _____

DECLARATION

1. I am aware of all the rules that determine dependency for availing medical facilities. I hereby reiterate that the declarations made by me to Human Resource Department in connection with the **eligibility** of the above patient are still valid and there is no change in any criterion which may alter his / her dependent. This is of a period subsequent to my declaration of dependents.
2. All the supporting documents listed below are enclosed with the claim form (please tick box as per submission).
   a) Original Referral note on Letterhead of Medical Practitioner mentioning **Reg. No. & Degree** **Yes** ☐
   b) Original Prescriptions for medicines & investigations on letterhead of Medical Practitioner mentioning **Reg. No. & Degree** **Yes** ☐
   c) Original Bills & Receipts containing VAT No. **Yes** ☐
   d) Original discharge card in case of IPD Patients **Yes** ☐
   e) Original Stickers & Invoice of implants. **Yes** ☐
   f) Xerox copies of all the reports. **Yes** ☐

   I understand that these documents are mandatory for settlement of medical claim and late submission of any of these documents shall not be entertained.
3. I have neither claimed nor would claim in future any expenses incurred on myself / this dependant under the same or a different system of treatment (Allopathy / Ayurvedic / Homeopathy) for the same ailment covering the same period either fully or partly.

_____	_____	_____
Signature of Claimant Date : _____	Signature of Section Head as Counter Signing Authority	Signature & Rubber Stamp of Sanctioning Authority

(For Office use only)

Recommended Amount (Rs.)		**Sanctioned Amount (Rs.)**	
Processed by		**(in figures)**	
Signature of Authorised MO		**(in words)**	
Signature of Competent Authority		Signature of Finance Authority	

Claim Details

(Employee should serially number the enclosed documents. Additional sheet may be used if the space is inadequate)
Please ensure the documents are put Date-wise in the same sequence as the claim details given below

Document No.	Receipt No.	Date	Name of Doctor/Hospital/Chemist	Amt Claimed Rs.	Amt Sanctioned Rs.
			Total Amount		