**CAPEXIL**

**MEDICAL REIMBURSEMENT CLAIM FORM**

 Date…………………..

**(To be filled in the Employee) For the year ………………..**

|  |
| --- |
|  |

|  |
| --- |
|  |

 A/c Code Employee Code:

Name:………………………………………………………………………………………….

Designation………………… Region…………………… Department…………………

|  |  |  |  |
| --- | --- | --- | --- |
|  | Medical Expenses | Remarks | IN CASE OF FAMILY |
|  Rs. |  P. |  | Name of Patient | Relationship | Age |
| SELF |  |  |  |  |  |  |
| FAMILY |  |  |  |  |  |  |
| TOTAL |  |  |  | Rupees ……………………………………. |
| **(To be filed in by the Office)** | Signature of the Claimant & Date |
| Verification and Passed for Payment by Admin. Department | Approval of Competent Authority | Passed for Payment by Accounts Department |
|  |  |  |

Received

Rs…………….. (Rupees …………………………………………………………)

Signature/Date

N.B.- Details of expenses to be given overleaf along with original Bill/Cash Memo/Receipts attached

**DETAILS OF EXPENSES**

**(Attach Separate Sheet if Required)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bill/Cash Memo/ Receipt No. | Date | Self | Family | Remarks |
|   Rs. P. |   Rs. P. |
|  |  |  |  |  |  |  |
| TOTAL |  |  |  |  |  |  |

Dated……………………….. (Signature of the Employee)