**CAPEXIL**

**MEDICAL REIMBURSEMENT CLAIM FORM**

Date…………………..

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

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|  |

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)