

INDIAN INSTITUTE OF SCIENCE, BANGALORE 560 012

CONTRIBUTORY HEALTH SERVICE SCHEME

Application for claiming reimbursement of Medical Expenses

(Separate form should be used for each patient)

1. Name (in Block Letter).....
2. Designation Department
3. CHSS No Bank Account No. Bank
4. Name of the Patient Relationship Employed / Not Employed
 [(1) if the spouse is employed, state whether or not he/she avails of medical reimbursement from his/her employer / organisation (2) In the case of children state the age]]
5. Name of the Medical Officer / Area Medical Officer / Specialist
6. No. and date of Consultation
7. Name of the Nursing Home / Hospital / Clinic
8. Period of Treatment From To
9. Particulars of Claim : (Prescription and Cash Memos should be attached)

MEDICINE

Sl. No.	Description of Medicines	Qty.	Amount	Sl. No.	Description of Medicines	Qty.	Amount
TOTAL				TOTAL			

INVESTIGATIONS

CONSULTATIONS / OTHERS

Sl. No.	Description of Investigations	Amount	Sl. No.	Details	Amount
TOTAL			TOTAL		

Total amount claimed Rs.....

I hereby declare that the statements made are true to the best of my knowledge and belief and that the person for whom the medical expenses were incurred, is wholly dependent upon me and his/her total income does not exceed Rs. 1,500/- per month.

Date :

Signature of Staff Members

ESSENTIALITY CERTIFICATE

I certify that the medicines and tests indicated in the claim were prescribed by me and were essential for his/her recovery/ prevention of serious deterioration in the condition.

Date :

CMO / MO / AMO

FOR OFFICE USE ONLY

Claim verified and also the list of inadmissible items. Claim bills admitted and passed for Rs
 (Rupeesonly)

Case Worker

Superintendent

Accounts Officer

Internal Auditor