MEDICAL CHARGES REIMBURSEMENT FORM

OUT DOOR

TO **Date:_____**
The SMO
Medical center
PMAS AAUR

Name: _____ **Designation: _____**
Department: _____ **Regular/contract: _____**
Name of Patient: _____ **Relation with the Claimant: _____**
Age of patient: _____ CNIC: _____Date of Birth: _____

Date	Consultation/labs	Amount

Amount Claimed Total: _____ **Verified amount by Medical Center:_____**

Checklist

No	Requirement	
1:	FRC	
2:	Refer slip by university doctor	
3:	Original Receipt/ bill by panel doctor/hospital/laboratory	
4:	Doctor Prescription copy	
5:	Each bill should be signed and verified by the applicant	

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is me/wholly dependent on me.

Date: ***Name and Signature of the claimant***

SMO

MEDICAL CHARGES REIMBURSEMENT FORM

IN DOOR / ADMISSION

TO **Date:_____**
The SMO
Medical center
PMAS AAU

Subject: **MEDICAL CHARGES REIMBURSEMENT FORM**

Name: _____ **Designation: _____**
Department:_____ **Regular/Contract: _____**
Name of Patient:_____ **Relation with the Claimant:_____**
Age of Patient:_____ **CNIC/B. Form:_____**
Date of Birth:_____ **Hospital Name:_____**
Date of Admission:_____ **Date of Discharge: _____**

S.No	No. & Date of Bill/Cash Memo	Detail	Amount Rs.

Check list

1:	FRC	
2:	Medical Docket	
3:	Non-Availability certificate/Reimbursement certificate	
4:	Discharge certificate	
5:	Detail bill	
6:	Bill of Medicine with doctor prescription	

Total Amount Claimed: _____ **Verified amount by Medical Center:_____**

I hereby declare that the statements in this application are true to the best of my knowledge and belief that the person for whom medical expenses were incurred is me/wholly dependent on me.

Date: **Name and Signature of the claimant**