KIRORI MAL COLLEGE, UNIVERSITY OF DELHI

REIMBURSEMENT FORM OF MEDICAL BILL

(FOR OFFICE USE)

DEPARTMENT .... SL. NO. .... DATE.......................

1. NAME & DESIGNATION OF EMPLOYEE : ______________________
2. BASIC PAY OF EMPLOYEE/ PENSIONER : ______________________
3. PLACE WHERE HUSBAND/WIFE OF THE EMPLOYEE IS EMPLOYED : ______________________
4. RESIDENTIAL ADDRESS : ______________________
   ____
5. WHETHER MEMBER OF W.U.S. HEALTH CENTRE (TOKEN NO.): ______________________
6. NAME OF PATIENT : ______________________
7. RELATIONSHIP AND AGE : ______________________
8. DOCTOR NAME/HOSPITAL : ______________________
9. NAME OF DISEASE : ______________________
10. PERIOD OF TREATMENT : ______________________
11. EMPLOYEE BANK A/C NO. : ______________________
12. MOBILE NUMBER : ______________________

(SIGNATURE OF EMPLOYEE WITH DATE)

(FOR O.P.D. TREATMENT)	**AMOUNT OF BILL**	**AMOUNT PASSED**
1. O.P.D. CONSULTATIONS CHARGE	:	....
2. TOTAL AMOUNT OF MEDICNE	:	....
3. LABORATORY TEST	:	....
4. OTHER CHARGES	:	....

(FOR HOSPITAL TREATMENT)

1) CONSULTATION FEES	:	....
2) TOTAL AMOUNT OF MEDICINE	:	....
3) LABORATORY TEST	:	....
4) ACCOMMODATION CHARGES	:	....
5) SURGERY/OPERATION CHARGES	:	....
6) MEDICAL CONSUMABLE ITEMS	:	....
7) CT SCAN/MRI CHARGES	:	....
8) ANAESTHESIA CHARGES	:	....
9) IMPLANT CHARGES	:	....
10) PHYSIOTHERAPY	:	....
11) OTHER CHARGES	:	....
12) **TOTAL AMOUNT OF BILL**	:	....

Assistant **S.O. A/cs** **Offg. A.O.** **Bursar** **Principal**