|  |  |
| --- | --- |
|  | NATIONAL AEROSPACE LABORATORIES, BENGALURU  HEALTH CENTRE  ***Hospital Expenses Reimbursement Form*** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health Centre Card No |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | Gr./Des |  | Divn./Sec |  | Basic Pay |  |
|  | | | | | | | | |
| Patient Name | |  | | | Relationship |  | Age |  |

Reimbursement claim for the following tests/ Investigations: ***Period:*** ………………….

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Sl. No | Consultancy/ Tests/ Procedure | Bill date | Speciality  (if Any) | Hospital/ Lab | Admissibility  (by MO-NAL) | Amount Claimed | | Amount admitted | |
| 1. |  |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |  |  |
| 5. |  |  |  |  |  |  |  |  |  |
| 6. |  |  |  |  |  |  |  |  |  |
| 7. |  |  |  |  |  |  |  |  |  |
| 8. |  |  |  |  |  |  |  |  |  |
| 9. |  |  |  |  |  |  |  |  |  |
| 10. |  |  |  |  |  |  |  |  |  |
| 11. |  |  |  |  |  |  |  |  |  |
| 12. |  |  |  |  |  |  |  |  |  |
| 13. |  |  |  |  |  |  |  |  |  |
| 14. |  |  |  |  |  |  |  |  |  |
| 15. |  |  |  |  |  |  |  |  |  |
| 16. |  |  |  |  |  |  |  |  |  |
| 17. |  |  |  |  |  |  |  |  |  |
| 18. |  |  |  |  |  |  |  |  |  |
|  |  |  | Total | |  |  |  |  |  |
|  |  |  | Signature of MO-NAL | |  |  |  |  |  |

* The patient was suffering from/ reason for recommendation: ……………………………………………………………………………

………………………………………….………………………………..

* The investigations/ procedures at Ser No …/…/…/.../…/…/…/…/…/…/…/ (if any) was advised by treating specialist. (Enclosed)

Bengaluru

Date: \_ \_/ \_ \_/ \_ \_ \_ \_ *Signature of the Medical Officer*

**Declaration**

*I Hereby declare that the statements made above are true to the best of my knowledge and belief and that the person for whom the medical expensed were incurred is wholly dependent on me and not in receipt of Rs 9000 pa. I also certify that the above medical bills are not claimed anywhere else either by self or by any other member thereof.*

Bengaluru

Date: \_ \_/ \_ \_/ \_ \_ \_ \_ Signature of Council Servant