PENSIONER'S

NATIONAL AEROSPACE LABORATORIES, BENGALURU
HEALTH CENTRE

Medicines Reimbursement Form

Name ………………………………………………. Health Centre Card No. : ……………………………….

Addres ………………………………………………. SBI, NAL Branch A/C No. : ……………………………….

………………………………………………. Last Pay Drawn : …………… Res. Ph. No. …………

Patient Name ………………………………………. Relationship : …………. Age : …………

Reimbursement claim for the following medicines: ***Period:*** ……………………..

Sl. No	Name of the Medicine purchased (in block letters)	Quantity	Bill date	Admissibility (by MO-NAL)	Claimed		Admitted (for office use)	
					Rs	Ps		
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
				Total				

Certificate

- I, Dr. ………………………….. certify that the above mentioned patient has been under my treatment & he/ she was required to have the above medicines which are essential for his/ her recovery/prevention of serious detioration in condition of his/her health.
- The patient was suffering from ………………………………………………………
- The medicines at Ser No …/…/…/../…/…/…/…/…/…/…/…/… (if any) was advised by treating specialist.
- The patient did not require hospitalisation and the case is not one of prolonged treatment.

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. I also undertake to refund the excess payments made, if any detected during post audit.

Date: _ _/ _ _/ _ _ _ _ *No. of Cash bills attached* ☐ *Signature of Council Servant*

Claim passed for payment for Rs: ………………………. (Rupees ………………………………………………………………………………….)

Verified by Administration : ……………………………………… *Test-Checked by Finance & Accounts : ……………………………….*

Reciept

Received a sum of Rs: ………………… (Rupees ……………………………………………………………………………….…..)

Bengaluru
Date: _ _/ _ _/ _ _ _ _ **(to be signed at the time of receiving payment)** *Signature of the Council Servant*