UNIVERSITY OF ENGINEERING AND TECHNOLOGY, PESHAWAR

Medical Form No. 00/2021

Voucher No _____

Dated: _____

Subject: <u>**RE-IMBURSEMENT OF MEDICAL BILLS FOR OCCASIONAL CLAIM**</u>

Sir,

1) Type of disease _____(Diabetes, Cancer, Renal diseases, Cardiac, Dental and Hypertension or any others)

2) When was last medical advice taken from practitioner? (in case of regular treatment):Dated____/___/20

3) Attached Form B (Family detail) in case bills are claimed of family dependent (to be provided only once for record only).   (Yes/No)

4) Has the Sehat Insaf Card/any other Government Hospital facilities have been explored. (Attach additional page if any).. (Yes / No)

5) Please clarify that such treatment and labs diagnosis are not available in the Government Hospital. (In case of treatment from other than the Government Hospital)   (Yes / No)

6) Bank detail of the claimant for reimbursement of the claim:

   a) Bank Accounts No:_____ Title of Account:_____

   b) Name of the Bank:_____ Bank Branch Code:_____

I have spent a sum of Rs._____ (Rupees _____ Only) on the treatment of _____ on account of _____ Consultation Fee, Laboratory Test, Ultra Sound fee, X-ray fee, regular medicine charges and dental treatment.). Necessary prescriptions along with Cash Memo(s) No._____ duly signed and attested by the _____ are enclosed herewith.

It is therefore requested that re-imbursement of the said amount may kindly be sanctioned and payment arranged to me.

Signature _____

Name _____

Designation _____

Section/Dept. _____

Certified that the claimant is a permanent employee of this University and he/she has actually spent the above amount on his/her own treatment/on the treatment of his/her dependent family and is, therefore, recommended for re-imbursement. The above information is correct to the best of my knowledge.

_____
Head of Section/Department

FOR OFFICE USE

The bills have been checked and corrected/found correct for Rs. _____/- and may kindly be allowed to reimbursed of the same amount to the above mention employee.

S.No.	Particular	Claimed Amount with date	Reimbursable Amount	Remarks
1.	Bill Already reimbursed			
2.	Current Bill (s)			

Medical Supdtt:

Deputy Director Accounts: