NATIONAL CENTRE FOR RADIO ASTROPHYSIS
TATA INSTITUTE OF FUNDAMENTAL RESEARCH

Pune University Campus, Pune - 411007.
Form for Medical Reimbursement Claim

Certificate granted to Shri _____

Employee TIFR Pune / Narayangaon / Retd. TIFR / DAE / BARC / DOS

CERTIFICATE AND MEDICAL BILL

Certified _____ was treated during the

Period from _____ to _____ for (name of the illness) _____

_____ and the clinical findings are _____

(injury etc.) _____

My bill which has been paid is as follows :

1. Consultation (includes professional service charges) Amount

   a) At the clinic Date Rs.

   _____
   _____
   _____

   b) At the home of the Patient (visitis) _____
   _____
   _____

2. Name and quantity of the medicines / tablets / powder / mixtures dispensed by the Doctor (Please write clearly)

   i Rs.
   ii Rs.
   iii Rs.

3. Details of injection (Please write clearly)

	Name	No. of injections	Cost of injection	Pricking charges	
i	_____	_____	_____	_____	Rs.
ii	_____	_____	_____	_____	Rs.
iii	_____	_____	_____	_____	Rs.

4. Dressing / suturing charges Rs.
5. Other charges if any Rs.

_____

Total Rs.

_____

Certified that no tonics, food / toiletry items has been prescribed (+)

1. Full name of Doctor :
2. Detailed Qualification :
3. Registration No. :
4. Place of Registration :
5. System of medicine used :

(+) If tonics, food or toiletry items are Prescribed, please give reasons thereof.

Doctor's Signature for the Bill with Rubber Stamp

Date :

Employee's Name :

Designation & Section :

Basic Pay :

Patient's relationship to the Employee :

CHSS No. :

Please reimburse me the following total amount being the medical expenses incurred by me for myself / my beneficiary

i) Doctor's Bill _____ Dt. _____ Rs.

ii) Cash Bill No._____ Dt. _____ Rs.

iii) Cash Bill No._____ Dt. _____ Rs.

iv) Cash Bill No._____ Dt. _____ Rs.

v) Cash Bill No._____ Dt. _____ Rs.

vi) Cash Bill No._____ Dt. _____ Rs.

vii) No. of X-rays taken
charges for each X-ray Rs.

viii) No. of pathology tests
Charges for each test Rs.

_____

Total Rs. _____

(Signature of the employee)

I.D. CODE Date :

Mob. No. & Email (Mandatory)

Note : Prescriptions from the Doctor and Cash Memo/s must be attached to the bill.