OPD CLAIM FORM (TO BE FILLED BY EMPLOYEE)

1	NAME OF EMPLOYEE				
2	HEALTH CARD #				
3	NAME OF PATIENT (FOR WHICH CLAIM IS MADE)				
4	AGE				
5	RELATION WITH EMPLOYEE (encircle the right choice)	Self	Spouse	Daughter	Son
6	PERIOD FOR WHICH CLAIM IS MADE (MONTH)				
7	**DETAILS OF AMOUNT CLAIMED**				
	INVOICE #:	**AMOUNT IN RS.**			
(i)					
(ii)					
(iii)					
	TOTAL AMOUNT CLAIMED				

CHECKLIST:

- Use separate claim forms if bills are for more than one patients / persons .
- Please ensure to attach the following documents along with this claim form. **(***Please indicate by tick mark **yourself)***

Sr#	DOCUMENTS	YES	NO	If "NO" Then Describe the Reason
(i)	Prescription of the doctor			
(ii)	Original Invoices of the doctor & lab etc			
(iii)	Computerized Pharmacy Invoices			
(iv)	Copy of Investigation's Reports			

We, the undersigned, do hereby declare that, to the best of our knowledge and belief, the foregoing particulars are true and correct. We authorize the company to obtain information from Doctor/Hospital/Pharmacy/Lab concerning the treatment for which claim is made.

_____
Employee's Signature with date

_____
Department Head/Branch Manager's Signature & Stamp

FOR COMPANY'S USE ONLY:

CLAIM DUE TO	CONSULTATION	PHARMACY	LABS	DIAGNOSTICS	DENTAL	OTHER (SPECIFY)
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
ANY REMARKS				DIAGNOSIS		
ANY DEDUCTION	Rs.			AMOUNT APPROVED		Rs.
CLAIM PROCESSED BY:				CLAIM APPROVED BY:		