

**ANDHRA BANK**  
(A GOVT. OF INDIA UNDERTAKING)

**ZONE/REGION :**

**BRANCH :**

**APPLICATION FOR MEDICAL REIMBURSEMENT UNDER HOSPITALISATION SCHEME**

**FOR SELF & FAMILY (SPOUSE & CHILDREN)**

1. Name of the Employee
2. Staff Code No. Designation  
  
Grade
3. Claim made for SELF/DEPENDANT
4. AMOUNT CLAIMED FOR Rs \_\_\_\_\_ (in words)

\_\_\_\_\_

- I. Details for Hospitalization & Expenditure - Incurred
  - a. Name of the Patient
  - b. Patient's relationship with the employee
  - c. Name of the Hospital/Nursing Home
  - d. Date of Admission / Operation / Discharge
  - e. Exact nature of Ailment
  - f. Nature of Operation / Treatment
  - g. Amount charged towards Room  
Rent/Bed charges @ Rs ..... ,..... per day  
for ..... days
  - h. Amount charged towards  
Surgeon's fee (Including Asst.  
Surgeon's fee)

- i **Operation Theatre**
- j. **Anesthetist's charges**
- k. **Physician / Consultant's / Specialist fee (No. of consultations/ visits etc)**
- l. **Amount charged towards Investigations/ Tests / X-rays Rs.....per plate  
No. of plates.**
- m. **EKG Tests charges**
- n. **Scan/Sonography etc. charges.**
- o. **Amount charged towards Pathological Tests – Blood, Urine etc. Details**
- p. **Amount charged towards Medicines/IV Fluids etc. administered in the hospital (Details are to be given) item wise, cost-wise.**
- q. **Medicines purchased from outside Chemists (to be supported by prescriptions)**
- r. **Ambulance charges, if any**
- s. **Other expenses, if any, Please specify**
- t. **Amount of Surcharge/Tax charged by the hospital.**
- u. **Amount of concession/discount given if any, by the hospital.**
- v. **Whether a proper Cash receipt for the actual amount received by the hospital is given on the Hospital/Nursing Home cash bill pad or on receipt pad with details.**

**Note : Receipts given on clinic letter heads, Doctor's personal letter-heads, on white papers etc. are not acceptable for sanction of reimbursement.**

**TOTAL AMOUNT OF THE ABOVE**

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**II INCASE CLAIM MADE FOR SELF**

- a. **Period of Absence and Nature of Leave Sanctioned.**
- b. **Date of Resuming to Duty**

**III. INCASE CLAIM MADE FOR SPOUSE**

- a. **Whether spouse is employed** **YES/NO.**
- b. **Name of the Organisation and Designation**
- c. **"Whether medical reimbursement facility is available with that organisation.**
- d. **Whether certificate from the employer of the spouse is enclosed.**
- e. **Whether declaration from the spouse is enclosed.**
- f. **Whether claim is made with in Six weeks from the date of discharge from the Hospital.**

**INCASE CLAIM MADE FOR DEPENDENT CHILDREN**

- a. **Age of the Son/Daughter**
- b. **Whether major Son/Daughter is working any where.**
- c. **Whether reimbursement claimed for children from Spouse's employer earlier. If any (details)**
- d. **Whether Daughter is Unmarried / Married /Widow, Specify.**

**CERTIFIED THAT THE PARTICULARS MENTIONED ABOVE ARE TRUE AND THE AMOUNT CLAIMED WAS ACTUALLY INCURRED BY ME. NONE OF THE CHILDREN FOR WHOM MEDICAL REIMBURSEMENT HAVE BEEN CLAIMED FOR IS AN EARNING MEMBER.**

**Place:**

**SIGNATURE OF THE EMPLOYEE**

**Date :**

**RECOMMENDATIONS OF THE BRANCH MANAGER/OFFICER - IN-CHARGE**

**DECLARATION OF SPOUSE**

I \_\_\_\_\_ Husband / Wife of Sri/ Smt. \_\_\_\_\_ working as Officer / Clerk / Sub Staff as \_\_\_\_\_ in Andhra Bank declare that I am not having medical reimbursement facility / not claiming any such facilities from my employer \_\_\_\_\_ and a certificate from my employer is enclosed.

I also declare that the amount claimed towards my hospitalization expenses were paid by my Husband / Wife Sri/ Smt. \_\_\_\_\_.

Signature \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

**Address:**