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'scharges

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. EGG Tests charges

n. Scan/Sonoaraohv 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 _____

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: