SAHA INSITUTE OF NUCLEAR PHYSICS
1/AF, BIDHAN NAGAR, KOLKATA – 700 064

Application for reimbursement of Medical Bill(s) for Employee Family under CMBS

ID No. _____

1. Name of the employee (in block letters) : _____
2. Designation : _____
3. Division/Section : _____Internal Tel. No._____
   Mobile: _____
4. Basic Salary : _____
5. Name of the Patient & Age : _____
6. Relationship to the employee : _____
7. **Name of the disease** (Mention of at least the general nature of the ailment is essential for processing the bill) : _____
8. Medical Advance, if any : _____
9. Amount claimed from : ___ ___ ___ to ___ ___ ___
   DD MM YYYY DD MM YYYY
10. Name of the physician (with qualification) & Reg. No. : _____

I am herewith submitting the bill(s) and other receipts for self/dependent member relating to medical attendance, pathological tests and other expenses and the medicines purchased by me on account of my/my dependent's illness diagnosed as _____ from which the patient had suffered during the period from _____ to _____. I shall be obliged if you kindly arrange for reimbursement of the medical expenses to the extent as permissible under the rules of the Institute. I had been on leave for _____ days on medical ground from _____ to _____.

I hereby declare that the following medical expenses were incurred in connection with the medical treatment of myself/dependent members of my family and the statement made below is true to the best of my knowledge and belief.

Date: _____ _____

Place: _____ Signature of the employee

11. Enclosures

a) No. of receipts for Consultation Fees:
b) No. of Prescriptions :
c) No. of receipts for Lab exams :
d) No. of Cash memos for Medicines :
e) No. of Receipt for other Expenses :
f) No. of Essentiality certificates :
g) No. of other Documents :

Total No. of Documents :

12. Summary

Nature of charge	Gross amount claimed	Amount recommended by MAC/Sub-committe
(A) Consultation		
(B) Lab. Exam.		
(C) Medicines		
(D) Bed Charge		
(E) Others		
	Total Rs.	Total Rs.

The Committee recommended the payment to the extent as shown above. The payment may be made, if approved by the Director.

Chairman / Chairperson

Prepared by Medical Attendant Medical Advisory Committee/Sub-committee

13. (A) CONSULTATION

i) Name of the Medical Attendant :

ii) Qualification :

Date of Consultation	At Chamber/Residence	Fees paid Rs.	Amount recommended (office use only)
i) ii) iii) iv)			
		Total Rs.	

(B) LABORATORY EXAMINATION

Nature of Examination/ Injection/ other expenses	Dates	Charges paid Rs.	Amount recommended (office use only)
		Total Rs.	

(C) MEDICINE

Name of the Shop	C.M. No.	Date	Amount paid Rs.	Amount recommended (office use only)
			Total Rs.	

(D) OTHERS

	C.M. No.	Date	Amount paid Rs.	Amount recommended (office use only)
			Total Rs.	

● FOR OFFICE USE ONLY ●

The sum of Rs. _____ (Rs. In words _____)
is being paid to Prof./Dr./Sri/Smt. _____
towards medical expenses.

Prepared by **Deputy Controller of Accounts** **Registrar** **Director**