PERFORMA FOR REIMBURSEMENT OF MEDICAL EXPENSES

(1) EMPLOYEE / APPLICANT INFORMATION

Name & Parentage: _____

Designation: _____ BPS: _____

Nature of Appointment: ☐ Regular ☐ TTS ☐ Contractual

CNIC No: _____ Cell Number: _____

Department / Office: _____

---

(2) PATIENT INFORMATION

(Please attach all the necessary medical documents, including CNIC)

Patient's Category: ☐ Employee (Self) ☐ Family Member

Patient's Name: _____

Relation with Employee: _____ Date of Birth (Age): _____(____ years)

Status of the Patient: ☐ Govt. Employee ☐ Semi-Govt Employee
(in case of Family Member) ☐ Private Employee ☐ Not Working

Nature / Detail of Disease: _____

_____

Type of Treatment: ☐ Indoor Treatment ☐ Outdoor Treatment
☐ Continuous Basis ☐ Non-Availability Certificate

---

(3) PARTICULARS OF REIMBURSEMENT CASE

Total Claimed Amount: Rs. _____ Type: ☐ Referred ☐ Emergency

Admission Date (for Indoor Treatment): _____ Discharge Date: _____

Hospital's Name & Address (if applicable): _____

Lab Tests / Continuous Treatment / Other Details: _____

_____

_____

---

(4) DECLARATION

I hereby declare that the above information is correct to the best of my knowledge and all original medical bills are attached herewith.

_____
Signature of Applicant
with Date

This case is hereby recommended and forwarded for reimbursement.

_____
Signature of HoD
with Date