HEALTH CARE CENTRE, GOVT. COLLEGE UNIVERSITY, FAISALABAD.

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) PATIENTIN 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 here by recommended and forwarded for reimbursement.

_____
The Dean,_____

_____
Signature of HOD with date

The Convener (MRC):

Deputy Chief Medical Officer: