SPORTS AUTHORITY OF INDIA

NETAJI SUBHAS REGIONAL-CENTRE LUCKNOW

MEDICAL REIMBURSEMENT CLAIM

1. Name and Designation of the Employee :
2. Name of the Patient & relationship with the employee. :
3. Total amount claimed : In figures :
   In words :
4. Name of the Doctor & Registration No. :
5. List of enclosures :
6. **Name of Medicine** **Cash Memo No. & Date** **Amount**

TOTAL

Signature of Employee

1. I hereby certify that patient has been under treatment and above mentioned medicines were prescribed by me and are/were not supplied by the hospital.
2. That the patient is/was not suffering from _____ and is/ was under my treatment from _____ to _____
3. The claim is verified for Rs. _____ (Rupees _____).

(Certificate applicable in case of hospitalization treatment only)

SIGNATURE OF MEDICAL OFFICER *WITH HIS SEAL/STAMP*

FOR OFFICE USE

1. Amount claimed so far : Rs. _____
2. Amount of the Present Claim : Rs. _____
3. Total amount claimed including this claim : Rs . _____
4. Certified that Shri/Km./Smt./Miss _____ is the son/ Daughter/Wife/Father/Mother/Husband of Shri/Smt./Kum. _____ as per the details of the family available in the office who is employed in the **SPORTS AUTHORITY OF INDIA** _____ The claim has been verified and passed for Rs. _____ (Rupees _____)

Certified that the claim is within the prescribed annual ceiling limits of Rs. _____

Dy. Director