(Only for use of NWDA Hqrs *employees*)

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the employee in BLOCK LETTERS)

1. (a) Name of the Employee :
   (b) Designation :
   (c) Basic Pay/Pay Level :
   (d)Employee Code No :
   (e)Full Address :
   (f)Mobile telephone No. and e-mail address, if any :

2. (a) Patient's Name :
   (b) Relationship with the employee :

3. Name & address of the hospital /diagnostic center/ Imaging center where treatment is taken or tests done :

4. Whether the hospital/diagnostic/imaging center empaneled under CGHS : Yes/No

5. Treatment for which reimbursement claimed
   (a) OPD Treatment/Test & investigations :
   (b) Indoor Treatment :

6. Whether treatment was taken in emergency : Yes/No

7. Whether prior permission was taken for the treatment : Yes/No

8. Whether subscribing to any heath/medical insurance scheme, If yes, amount claimed received : Yes/No

9. Details of Medical Advance taken, if any :

10. Total amount claimed
    (a) OPD Treatment :
    (b) Indoor Treatment :
    (c) Test/Investigation :

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me.

Date:.....

Place:..... Signature of the Employee

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APPLICATION FOR ADVANCE FOR MEDICAL TREATMENT

1.	Name	
2.	Designation	
3.	Place of posting	
4.	Basic Pay	
5.	Name of the patient	
6.	Relationship with the Government Servant.	
7.	Whether treatment is received as Inpatient or Out-patient.	
8.	Name of the Hospital in which patient is treated and whether it is a recognized one	
9.	Anticipated cost of treatment as certified by the Medical Officer/Specialist.	
10.	Amount of advance required.	

I declare that the particulars furnished above are correct.

Place_____

Date_____ Signature of Employee