



पीईसी लिमिटेड : नई दिल्ली  
PEC LIMITED : NEW DELHI



FORM FOR MEDICAL REIMBURSEMENT - OPD

Employee No.	Name of Employee	Designation	Division	Scale of Pay (₹)	Medical Card No.

Details of Patient(s)

Name of Patient(s)	Age	Relation

Details of Claims

A. For Lab Tests

S. No.	Nature of Test	Name of Test Centre/Lab	Enclosed Bill No. & Date	Amount Claimed(₹)	Amount admitted by A&E(₹)

B. For Medicines

S. No.	Name of Chemist	Enclosed Bill No. & Date	Amount Claimed(₹)	Amount admitted by A&E(₹)

C. For Other Claims

S. No.	Details of Payment	Enclosed Bill No. & Date	Amount Claimed(₹)	Amount admitted by A&E(₹)

Total (A+B+C): (₹)

Declaration:

- ✓ I am not claiming any medical reimbursement from anywhere else including medical insurance.
- ✓ I hereby declare that statements are true to the best of my knowledge and belief and the person(s) for whom expenses were incurred is/are wholly dependent upon me.

Applicant's Signature:-

Date:-

Pay ₹:-	Signature	Name	Designation	Date
Checked by DM (F&A):-				
Approved by M (F&A):-				
If OPD Bill more than Rs. 5000/-, Approval of HOD, Personnel				

\*Sanctioned Copy to Employee