PROLONG REIMBURSEMENT FORMAT

(Note: Separate Format to be filled for each Prescription)

EMP NO : NAME:

PRESCRIPTION SL NO :

CONSULTANCY FEE DETAILS

RECEIPT NO	RECEIPT DATE	CLAIM TYPE	DEPENDENT NAME	CONSULTANCY TYPE	CLAIM AMOUNT
		SELF/DEPENDENT		PHYSICIAN/SPECIALIST	

LAB & PATH TEST DETAILS

TEST NAME	RECEIPT NO	RECEIPT DATE	CLAIM AMOUNT

MEDICINE DETAILS

RECEIPT NO	RECEIPT DATE	DATE FROM	NO OF DAYS	CLAIM AMOUNT

(Signature)

OPD REIMBURSEMENT FORMAT

(Note: Separate Format to be filled for each Prescription)

EMP NO : NAME:

CLAIM FOR : SELF/DEPENENT DOCTOR TYPE : GOVERNMENT/RITES CONSULTANT/RAILWAY CONSULTANT/MBBS-BAMS

CONSULTANCY FEE DETAILS

RECEIPT NO	RECEIPT DATE	CONSULTANCY TYPE	CLAIM AMOUNT
		PHYSICIAN/SPECIALIST	

LAB & PATH TEST DETAILS

TEST RECEIPT NO	TEST RECEIPT DATE	TEST NAME	CLAIM AMOUNT

MEDICINE DETAILS

MEDICINE RECEIPT NO	MEDICINE RECEIPT DATE	DATE FROM	NO OF DAYS	CLAIM AMOUNT

DENTAL PROCEDURE

DENTAL RECEIPT NO	DENTAL RECEIPT DATE	PROCEDURE NAME	CLAIM AMOUNT

(Signature)