

# Raman Research Institute

## Medical Claim Form

Name of the Employee	:				
Patient's Name	:	1	2	3	4
Relationship to the Employee	:				
Nature of illness	:				
Place at which treatment was taken	:				

### I If Out-Patient:

Consultation Charges 1. Physician (s) 2. Specialist (s)	:				
Medicines purchased (list total only) Attach prescriptions for all medicines. If bills are hand written, please attach a list in legible form.	:				
Tests Attach receipts and referrals, as well as test reports	:				
Amount Claimed - I	:				

**II If In-Patient:**

Name of the Hospital. Attach referral from doctor and the discharge summary	:				
Medicines purchased (list total only) Attach prescriptions for all medicines. If bills are hand written, please attach a list in legible form.	:				
Charges for Tests. Attach the Test reports, along with bills	:				
Whether the hospital bill was settled by the Institute.	:				
Amount Claimed - II	:				
Total Amount Claimed - I + II	:				
Advance taken, if any	:				
Number of enclosures	:				

Date:

Certified that the above treatment was necessary

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Signature of the Employee

*Please obtain an acknowledgement from the clinic*