cmpdi

Form at - F

Contributory Post Retirement Medicare Scheme for Non-Executives

CLAIM FORM FOR REIMBURSEMENT OF MEDICAL EXPENSES INCURRED BY SEPERATETD NON – EXECUTIVES

For Out Patient/Domiciliary treatment

Name : .....

Code (Employee No/EIS No) : .....

Registration of Medical Card : CMPDI/ HQ/ ADMN/ CPRMS-NE /.....

Present address with Pin Code : .....

at which the Cheque is to be sent .....

Bank Name : ..... & A/C No : .....

1 Name of the Patient : .....

2 Relationship with the Retired Non executive : .....

3 Place at which patient fell ill : .....

4 If treatment taken at place rather than place of residence, give reasonsons. : .....

5 Name of the Hospital & Doctor from where treatment taken : .....

6 Qualification of the doctor : .....

Note : 1) Doctor's prescription and cash memos in original should be attached.
2) Receipts of amount claimed should be enclosed.
3) Separate claims should prepared for each patient and each spell of treatment.

(To be certified by the retired Non-executive)

I do hereby declare that :

i) The statements made in the claim are true to the best of my knowledge and belief.
ii) I am a member of Contributory Scheme for Post Retirement Medical Facilities and my medical Card is valid Since .....
iii) I continue to fulfill the conditions of eligibility for availing the benefits under the scheme.
iv) The Medical expenses were incurred for self/spouse.
v) I fully understand that the Company may refuse/terminate my membership of the scheme at any time without any notice and without assigning any reason.
VIII) Myself and my spouse are not availing any medical facilities from or through the Central/State Govt./Public Sector Undertaking/Quasi Govt Body or any Medical Insurance Company either in individual capacity or a dependent.

Date .

(Signature of the retired Non-executives/ living spouse in case of death.

The claim has been scrutinised and recommended for payment of Rs. _____

(Rupees _____) only

Chief of Medical Service

(To be filled in by the Accounts Department)

Claim passed for payment of Rupees (in words) .....

(in figures) .....

Accountant Sr A O /A.O. Date :

Format F

CONTRIBUTORY POST RETIREMENT MEDICARE SCHEME FOR NON EXECUTIVES OF OIL & ITS SUBSIDIARIES

DETAILS OF THE AMOUNT CLAIMED

	AMOUNT Rs.	P.	HOSPITALIZATION CASE	AMOUNT Rs.	P.
1. CONSULATATION FEES : Date Amount a) b) C) d) TOTAL 1.			5. ACCOMMODATION CHARGES FOR THE PERIOD FROM : TO @ Rs. ..... per day		
2. INJECTION ADMINISTRATION FEES : Date Amount a) b) C) d) TOTAL 2.			6. SURGICAL OPERATION OR CONFINEMENT CHARGES		
3. MEDICINES PURCHASED FROM MARKET : Date Amount a) b) C) d) TOTAL 3.			7. COST OF MEDICINES		
A. TOTAL (1+ 2+ 3)			C. TOTAL (5+ 6+ 7)		
4. PATHOLOGICAL / OTHER TESTS Name of the test Amount a) b) C) d)			TOTAL AMOUNT CLAIMED (A + B + C) In figures - In words:-		
B. TOTAL 4.					

Date :

(Signature of the separated Non- Executive/ living spouse in case of death)

DETAILS OF AMOUNT DISALLOWED AMOUNT

Reason :

1.
2.
3.
4.

Sr. A.O./A.O.