



GU.HA.SA.CHA.MODH GNATI HITECHCHHU MANDAL, RAJKOT

3/14 Jagnath Plot, Rajkot, Gujarat, India- 360001.

(M) +91 9033232508

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled by principal member in BLOCK LETTERS)

Name of the principal member of Gu.Ha.Sa.Cha. Mandal: _____

Member ID (Optional) : _____ (As per Gnati Office Register)

Full Address: _____

Mobile No. and E-mail ID if any: _____

Patient's Name: _____ Occupation:- _____

Relation with the principal member: _____

Name and Address of the Hospital/diagnostic center/imaging center

Where treatment is taken or test done. : _____

Treatment for which reimbursement is claimed:

1. OPD Treatment 2. Diagnostic test & Investigation 3. Indoor Treatment
4. Hospitalization 5. Other post hospital Charges.

Whether subscribing any Employer health/medical Insurance scheme/PMJAY: YES / NO

If yes, patient's PMJAY/UDAI CARD NO: _____ Amount Received: _____

TOTAL AMOUNT CLAIMED:

1. OPD Treatment Expenses : Rs. _____
2. Indoor Treatment Expenses : Rs. _____
3. Test, pre and post Hospitalization Expenses : Rs. _____
Total Amount: Rs. _____ (For which all Bills in original Attached herewith)

Detail of Emergency advance received on behalf of Mandal if any: _____

Name of the Bank : _____ S.B. A/c No. : _____

Branch MICR code : _____ IFSC code : _____

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. I and the patient are current members of GU.HA.SA.CHA. MANDAL at the time of treatment. I agree for the reimbursement as is admissible under the rules of Mandal.

Place : _____

Date : _____

Signature/Thumb Impression of Member

For Office Use :

Total claimed amount: Rs. _____ Advance paid if any: _____ After scrutinizing the claim Net amount approved for the payment by committee : Rs. _____

Gen.Secretary

Treasurer

President

Trustees