

**H.P.T.R.6**  
**MEDICAL CHARGES REIMBURSEMENT FORM**

1. Name and Designation : .....
2. Office in which Employed : .....
3. Basic Pay : .....
4. Name of Patient & relation  
with the Claimant
5. Period of Illness : .....
6. PARTICULARS OF TREATMENT:

Item Names	Charges	Details of Cash-Memos etc.
(i) Medicines (Name)		
(ii) Laboratory Tests/Ambulance/Consultancy/Indoor Room/Others (Specify)		

6. Total Claim                      Rs.....

7. Less- Advance Drawn *vide* T/V

No..... Dt.....Rs.....

8. Net Amount Payable                      Rs.....

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent on me.

Date .....

*Signature of the DDO*

**VARIFICATION CERTIFICATE**

I, Dr ..... Hereby certify that .....

Suffering from ..... and is /was under my treatment from .....

To ..... And that the above mentioned medicines/ test were prescribed by me in this connection.

This claim is verified for Rs.....

Date.....

(Signature of Medical Officer)  
Designation & Seal

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Passed for Rs.....(Rupees.....)

And included in Bill No.....Dated.....

*(Signature of Controlling Officer)*

*(Signature of the DDO)*

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**INSTRUCTIONS**

1. List all the medicines, tests etc. individually.
2. Attach Cash-Memos duly verified.
3. Mention dates of admission to the Hospital, Stay etc.