CENTRE FOR DNA FINGERPRINTING AND DIAGNOSTICS
Survey Nos. 584 to 587, 634 & 635, Opp: Metro Rail Pillar No. NUP-9,
Inner Ring Road, Uppal, Hyderabad – 500 039, Telangana State
Ph: +91-40-27216018, www.cdfd.org.in

CDFD

S B A/c. No._____

Bank Name_____

Telephone No._____

FORM OF APPLICATION FOR MEDICAL CLAIM

1. Name (in block letters) & Staff No. :

2. Designation :

3. State Whether you are a regular employee or a project employee :

4. Basic pay :

5. Residential Address :

6. Name of the patient and his/her relationship with the employee :

7. Place of duty :

8. Nature of treatment and its duration : Out patient/ In patient

9. Name & designation of the medical officer consulted and the Hospital / Dispensary to which attached :

10. Details of the amount claimed :
    i) Consultation
    ii) Clinical/Pathological tests
    iii) Cost of medicines : (Details given overleaf)
    iv) Others (Please specify)

    Total ₹ :

11. List of enclosures :

Details of Medicines

S.No.	Name of the drug store / chemist	Cash Memo No.	Date	Medicine(s)	Amount of each medicine	Total of each cash memo

DECLARATION

1. I certify that the patient for whom medical reimbursement claim has been made in the bill is wholly dependent upon me.
2. I Certify that my Wife/Husband is not employed in a Government/Semi Government service and he/she has not submitted any claim.
3. I hereby declare that the statements in this form of application are true to best of my knowledge and belief.
4. I hereby declare that the statements in the application form are true to the best of my knowledge and belief and that the person/persons for whom medical expenses were incurred is/are wholly dependent upon me.

Signature of the Claimant:

Date _____

MEDICAL BRANCH : Claimed for : ₹ Passed for ₹

PARTICULARS OF MEDICINES & CHARGES NOT ADMITTED

1. .....
2. .....
3. .....
4. .....
5. .....

Signature

ACCOUNTS BRANCH

Claim passed for ₹_____ (Rupees _____

_____ Only)