COMSATS Institute of Information Technology, Lahore

MEDICAL CLAIM FORM

Date: ....

Name of Employee:________________________________

Designation: ________________________________

Policy No: ________________________________

Name of Patient: ________________________

Relation with Employee: ________________

Nature of Claim: Hospitalization OPD

Sr. No.	Date of Treatment	Clinic/ Doctor/ Hospital Name	Consultation/Lab Test fee (Rs.)	Medicine (Rs.)	Total Amount (Rs.)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
			Grand Total		

(In words): ____

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Declaration:

I declare that the information given in this form is correct to the best of my knowledge.

Submitted by:
(Signature): ____________________

Countersigned by (HOD):
Signature: _________________________

Name: ______________________________

Designation: ________________________

[For official use]

Claim Forwarded by:
Signature and Stamp of official of CIIT): ________________

Date: ____________________