

**MAHANAGAR TELEPHONE  
MEDICAL REIMBURSEMENT CLAIM FORM**

Code No \_\_\_\_\_

Name of Official :- \_\_\_\_\_

Staff No :- \_\_\_\_\_

Pay :- \_\_\_\_\_

Name of Unit :- \_\_\_\_\_

A. I, \_\_\_\_\_ St. No - \_\_\_\_\_ do hereby certify that,

(1) I have undergone treatment under Dr. \_\_\_\_\_  
at his clinic at \_\_\_\_\_  
at my residence \_\_\_\_\_

(2) My dependant Wife/Daughter/Son/Father/Mother as already declared by me  
has undergone treatment under Dr. \_\_\_\_\_ at his/her  
clinic at \_\_\_\_\_  
at my residence \_\_\_\_\_

B. I submit the following:-

1. Doctors Prescription

2. Cash Memo No.	Amount Rs.	Cash Memo No.	Amount Rs.
i) _____	_____	vi) _____	_____
ii) _____	_____	vii) _____	_____
iii) _____	_____	viii) _____	_____
iv) _____	_____	ix) _____	_____
v) _____	_____	x) _____	_____

3. Doctors bill for supply of medicine/injection charges.
4. Receipt for doctors consultation.
5. Receipt for test carried out.
6. Receipt for special charges.
7. Any other claim.

My claim is for a total sum of:

Consultation : Rs. \_\_\_\_\_

Cash Memos : Rs. \_\_\_\_\_

Test : Rs. \_\_\_\_\_

Total : Rs. \_\_\_\_\_

My basic is Rs. \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Designation: \_\_\_\_\_

Staff No: \_\_\_\_\_

Date: \_\_\_\_\_

Place: \_\_\_\_\_

Signature of controlling officer

(FOR OFFICE USE ONLY)

Claim Scrutinized:

After disallowing inadmissible item it has been admitted for Rs. \_\_\_\_\_

(Rupees \_\_\_\_\_)

Please Pay Rs. \_\_\_\_\_

(Rupees - \_\_\_\_\_ )

to Shri / Shrimati / Kumari \_\_\_\_\_

Progressive Total Rs. \_\_\_\_\_

Certified that the entries have been made in the register.

DA.

Note:-

1. Portion not required should be deleted.
2. Separate claim should be made for self and family.

Account Officer Cash (\_\_\_\_\_  
MTNL, Mumbai

Received Payment.  
Signature