

CAPITAL HOSPITAL ISLAMABAD

APPLICATION FOR RE-IMBURSEMENT OF MEDICAL CHARGES

To, The Executive Director,
Capital Hospital CDA,
Islamabad

Subject:- REQUEST FOR RE-IMBURSEMENT OF MEDICAL CHARGES.

- a) Name _____
CNIC No _____
- b) Employee Status _____ (Regular/Retired/Contract)
- c) Employment No _____ or PPO No (For Rtd) _____
- d) Vendor No. (from IT, Main Chairman Office) _____
- e) Designation & Directorate _____
Particular of Patient _____
- f) Name _____ Age _____
- g) Sex _____ Medical Card No _____
- h) Relationship with Employee (Self, W/O, M/O, F/O, D/O, S/O)
- i) Referred by _____
- j) Referred to _____

Kindly reimburse an amount of Rs. _____ as the same have been spent from my own pocket.

Items required: Reference slip, Medical Card, Pay Slip, Original bills verified by CDA Doctor.

Date _____

Yours Obediently

Remarks of referring Doctors ()

Test a) _____
b) _____

Result a) _____
b) _____

Recommended / Not Recommended for re-imburement

Approved / Not Approved for Scrutiny as per rules

Signature of Specialist

Director Project Development

Executive Director

CAPITAL HOSPITAL
RE-IMBURSEMENT SUMMARY

Detail of bills

S.No	Dated	Cash Memo No	Test / Medicine	Hospital/Chemist Name	Amount	Amount Sanctioned
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Above bill have been checked and found correct
Amounting to Rs. _____

Scrutiny Officer

Bill scrutinized & verified
for Rs. _____

Director Project Development
Capital Hospital CDA

Recommended / Sanctioned for Rs. _____
Rupees _____

Executive Director
Capital Hospital, CDA

Sanctioned for Rs _____
Rupees _____

FA / Member CDA