Crescent Star Insurance Limited.

OUT-PATIENT EXPENSES CLAIM FORM

Company Name. _____ **Policy No.** _____

Employee's Name. _____ **Member ID.** _____

Health Card No. _____ **Employee ID.** _____

For the month of _____

			NATURE OF EXPENSES IN RUPEES			AMOUNT CLAIMED IN RUPEES		TOTAL
S. NO.	CASH MEMO/ RECEIPT NO.	DATE	MEDICINES	CONSULTANCY	TESTS	PATIENT'S NAME	RELATIONSHIP WITH THE EMPLOYEE	IN RUPEES
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
Total								

I hereby declare that the amounts stated above are correct and were incurred by me for medical expenses.

Check List

- ☐ Treating Physicians prescription (Duly signed & Stapmed)
- ☐ Receipts for purchase of prescribed medication (With name & date of the Patient)
- ☐ Lab reports.
- ☐ Attach a copy of eye card for the reimbursement of Glasses claim
- ☐ For Dental claim please provide the detailed bill with teeth numbers and x-rays.
- ☐ Vaccination Card

Date | **Signature of Employee** | **Verification by Employer with company rubber stamp**

Note : Please attach all original bills.