MEDICAL RE-IMBURSEMENT BILL CALCULATION SHEET

Employee Name with ID :

Name of Patient and Relationship :

Name of Treating Hospital :

Whether Govt./Panel/Pvt. Hospital :

Period of Treatment **From** **To**

SL. No.	Name of the Treatment/ Investigation	Treatment/ Investigation DGEHS Code	Rates Charged by the Hospital	DGEHS approved Rate	Restricted Claim	Bill No. & Date/ Other Remarks
1	**CONSULTATION CHARGES**					
		TOTAL (1)				
2	**INVESTIGATION/TREATMENT/PROCEDURE CHARGES**					
		TOTAL (2)				
3	**MEDICAL CHARGES**					
		TOTAL (3)				
4	**OTHER CHARGES**					
		TOTAL (4)				
TOTAL						

Signature of DDO

Signature of HOS