**V.O.CHIDAMBARANAR PORT TRUST**

THE DULY FILLED IN PROFORMA FOR SUBMITTING MEDICAL REIMBURSEMENT BILLS FOR REIMBURSEMENT OF CHARGES FOR **HEARING AID WORKING/ RETIRED** EMPLOYEES

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| --- | --- | --- |
| Sl.No. | **Details** | **Remarks** |
| 1. | Name of the pensioner |  |
| 2. | Designation |  |
| 3. | Pensioner No. |  |
| 4. | Medical ID No. |  |
| 5. | Name of the patient |  |
| 6. | Relationship with pensioner1. Self
2. Spouse
 |  |
| 7. | Whether Hearing Aid referral by ENT & Referral letter date |  |
| 8. | Bill amount of the Hearing Aid claimed with invoice, date and number |  |
| 9. | Whether MoU exists with the port Hospital and if so with date | **If yes, the details of the same to be furnished** |
| 11. | Sl. No. of Delegation of Powers |  |
| 12. | Enclosures:1. No. of Original Bills
2. Referral letter by ENT specialist
3. Copy of Medical ID card (If the patient is dependent)
4. Proof of payment by RTGS/NEFT
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Date: **DEPUTY CHIEF MEDICAL OFFICER**

For use in Finance Department for passing the bills.

Approved by:

SAP File No. with reference to page

ACCOUNTS OFFICER (Medical Bills)

Checklist for reimbursement charges for Hearing Aid dated : 30.06.2018