CMS ID: CMS/201 **Enrolment No.:** (Office use only)

Form No. : CMS 04

Office of
CONTRIBUTORY MEDICAL SCHEME
IIEST, Shibpur, Howrah

MEDICAL CLAIM FORM

1. Employee's Name: …… 2. Employee Code: ……

3. Designation: ……4. Department:……

5. Pay Band & GP:……6.Basic Pay:……7.Ph.No.……

8.Patient's Name……..9.Age……..10.Relationship: ……

I. Documents enclosed : (May attach extra page following the prescribed pro-forma, if required)

Sl. No.	Particulars	Marked As	Hospital's/Doctor's Name	No. of Pages Enclosed
		--		
		--		
		--		
		--		
		--		
		--		
		--		
		--		
		--		
		--		

II. Bills enclosed : (May attach extra page following the prescribed pro-forma, if required)

Sl. No.	Bill No. & Date	Marked As	Hospital's/Doctor's Name	Amount Rs.	Amount P.
		--			
		--			
		--			
		--			
		--			
		--			
		--			
		--			
		--			
		--			
Amount Claimed:			**Total:**	0	00
In words : Rupees					

Date : **Signature of the Claimant**

Amount passed for payment : Rs._____ In words: Rs._____ Remarks, if any : **Medical Officer**	**Audit's Observation, If any :**

N.B.: Please enclose attested or self certified or original documents along with the bill(s) in original