



## OUTPATIENT EXPENSE CLAIM FORM

Name of Attending Physician : \_\_\_\_\_

Name of Employee : \_\_\_\_\_

Name of Employer : \_\_\_\_\_

S.Nos.	Name of patient	Date of visit	Complaint/ Diagnosis	Physician's Fee	Medicines Prescribed	Total Bill for this Visit

*\* Please attach doctor's prescriptions(s) and Cash memos/bills of medicines purchase with this form.*

\_\_\_\_\_  
Verified by authorised  
Officer of employer

\_\_\_\_\_  
Signature  
of Employee

\_\_\_\_\_  
Signature and seal  
of attending physician