APPLICATION FOR MEDICAL REIMBURSEMENT

(Please fill ALL fields)

I would like to apply for medical reimbursement according to my eligibility as allowed by the University. The details are as follows:-

Name of Staff :…… Staff No. :……

K/C/D/I/O :…… H/P No. :……..

Name of Patients:

No	Name	Relationship	Diagnosis / Treatment	Hospital/ Clinic	Amount (RM)
1					
2					
3					
4					
5					
Total Claim					

(Please use another form whenever necessary)

Thank you, Wassalam

……
(Signature of applicant)

Date: ……

To avoid delay in payment, please ensure that the particulars are filled completely. Please attach receipt for every claim. Please make your own copy before submit (**if necessary)**

Office use (calculation) :

		Hospital Charged	Eligibility
Ward	:		
Remaining 30%	:		
TOTAL	:		