

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):	<u>Hospital Charged</u>	<u>Eligibility</u>
Ward :	_____	_____
Remaining 30% :	_____	_____
TOTAL :	_____	_____