**PAKISTAN INDUSTRIAL TECHNICAL ASSISTANCE CENTRE (PITAC)**

APPLICATION FORM FOR REIMBURSEMENT OF MEDICAL CHARGES IN RESPECT OF SERVING / RETIRED SERVANT (PENSIONERS) AND HIS / HER DEPENDENTS

PART-A

1. Name, designation, BPS, of the serving/retired (pensioner) PITAC employee, (Alive/Deceased)

2. Name of the patient and relationship with the claimant as dependent,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Diagnosis of the patient

4. PPO No. for retired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. List of medicines with quantity (in case of Chronic disease) / hospital bill/consultancy fee/laboratory and other diagnostic charges etc. for which reimbursement is claimed through this bill (format attached).

6. Total Amount Claimed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PART-B

Certificates by PITAC employee (or member of his/her family in case of deceased Government servant) Certified that:

i) The member(s) of my family for whose treatment reimbursement has been claimed is wholly dependent upon me.

ii) The claim was not drawn before.

iii) I shall have no objection to the recovery of my amount overpaid, if any, from my pay/pension or otherwise.

Signature: FULL NAME OF THE PITAC EMPLOYEE or (claimant family member in case of deceased)

Date:

(IN BLOCKLETTERS)

CERTIFICATESBYTHEAUTHORIZEDMEDICALATTENDANT

(Medical Attendant may tick (√) or cross (x) the boxes as the case may be)

1. It is certified that the medicines/drugs/hospitalization/clinical tests/examinations enclosed at proforma were essential for the recovery and restoration of the patient, Mr. /Mrs. /Miss.
2. It is certified that the disease of the abovementioned patient was chronic in nature.

Dated:

Signature Designation Official Stamp

COUNTERSIGNATURES

PITAC Authority or Authorized Officer Hospital Authority or any Authorized Officer i.e. Assistant Director / Manager / Director / Administrator etc.

Signature Designation Official Stamp

(Revision-I) 25th June, 2018Signature Designation Official Stamp

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| --- | --- | --- | --- | --- |
| S.# | No. & Date ofBill/Cash Memo | Name of the ChemistShop/Hospital/Clinic/Dispensary | Name of Drugs/Medicines withQuantity/Details of Tests or Consultancy Fee etc.  | AmountRs. |
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| **Total Amount** |  |

Note: Please use additional Form if required.

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| **For PITAC employee**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Section/Shop\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **For Authorized Medical Attendant**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Official Stamp\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |