



INFORMATION OF EMPLOYEE/PATIENT

Employee's Name

Designation

Patient's Name

Date of Birth

 / /
Day Month Year

Age

Male

Female

Relation with Employee

Patient's Full Address

Phone No of Employee

Signature of Employee

REPORT OF ATTENDING PHYSICIAN / SURGEON

Name of Consultant

Address

Phone No

Admission Date

Date of Discharge

Hospital Registration No

Admission due to

Emergency

Non-Emergency

Nature of Admission

Surgical

Non-Surgical

Maternity

Normal

Caesarean

Diagnosis/Operation

Doctor's Signature & Date / Stamp

REPORT FROM HOSPITAL

Hospital Name & Address

Surgeon's Fee

 Rs.

Anesthetist's Fee

 Rs.

Room/Ward Rent

 Rs.

Operation Theater/Labor Room Expenses

 Rs.

Medicine Cost

 Rs.

Consultant/Medical Officer Visit Fee

 Rs.

Lab. Test Cost

 Rs.

Examination Cost

 Rs.

Miscellaneous Expenses

 Rs.

Total Expenses

 Rs.

Hospital's Official Stamp

VERIFICATION OF THE EMPLOYEE

Verification by Additional Registrar
(BPS 17-22)

Verification by Deputy Registrar Administration
(BPS 01-16)

Claim Receiving Date

COMMENTS

INSTRUCTIONS

- Incomplete form is unacceptable and will be returned to the concerned employee.
- Please fill the form clearly so that the information is legible
- Please do not overwrite or use correction fluid on this form
- Please attach all the required documents and original receipts along with this form

- Photocopy of LUMHS Health Card
- Photocopy of employee's and patient's CNIC/B-Form (as applicable)
- All original bills with dates. Bills without dates will not be entertained
- Consultant's recommendation for hospitalization
- Medicines used during hospitalization
- Consultant's advise for laboratory investigations during hospitalization
- Attested copies of laboratory tests and discharge card
- Attested copy of Birth Certificate of the new born (in case of maternity)