MEDICAL EXPENSE CLAIM FORM

## Use this form to claim eligible expenses

✔ Expense claim form is filled properly

✔Employee ID Attached ✔ Original receipts are attached

|  |
| --- |
| Employe Information  |
| EMPLOYEE NAME LAST | FIRST | MIDDLE | BANK ACCOUNT# |
|  |  |  |  |  |  |  |  |  |  |
| FULL ADDRESS | SOCIAL SECURITY # (if SA# not known) |
| CITY | STATE | ZIP CODE | CONTACT NUMBER |
| EMAIL ADDRESS | IMMEDIATE MANAGER NAME |
| Claim Details |
| EMPLOYMENT HISTORY | DEPARTMENT NAME | EXPENSE NATURE | APPROVED LIMIT | AMOUNT REQUESTED |
|  |  |  |  | $ |
|  |  |  |  | $ |
|  |  |  |  | $ |
|  |  |  |  | $ |
|  |  |  |  | $ |
|  |  |  |  | $ |
|  |  |  | TOTAL | $ |
| Employee Confirmation |
| I, \_\_\_\_\_\_\_\_\_\_\_\_ confirm that the above-mentioned expenses have been paid by me and are eligible as per the rules mentioned in manual book \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. As per current date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ these expenses have not been reimbursed to me at my account number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. 1. I fully understand that the expenses for which I am reimbursed cannot claim any income tax deduction or credit.
2. I also acknowledge that I can be further asked to submit document/s for these expenses.
3. I am with all my true intentions, willing to get a reimburse up-to my actual expenses, which I incurred.
4. All above provided information is accurate and true as per my knowledge.
 |
| Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DATE: \_\_\_ /\_\_\_ / \_\_\_\_\_\_ |
| Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DATE: \_\_\_ /\_\_\_ / \_\_\_\_\_\_ |