The Open University of Sri Lanka
General Administration Division

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Serial No: -

(Form No. 03)

Medical Welfare Scheme – 2024

Surgical & Hospital Expenses

Application for Reimbursement **(To be submitted to the General Administration Within 90 days)**

Employee Number - ……...……

Name with Initials - …..……...……

ID No. - ……..……

Division /Department /Faculty /Center - ……..……

Contact No Mobile Number - ……..……..…

Extension Number - ……...……..

Scheme (Pl. Tick the box) - ☐ ☐ Individual Family

Request Amount - ……

Dependent Details-

Name (In Full) - ……

Relationship - ……

Injury (Please state)

Date & Place of Accident - ……

Precisely How the Accident Occurred - ……

Nature & Extent of Injuries - ……..

Illness- (Please state)

Nature of Description of Illness - ……...……...

Date of Commencement of Illness - ……...……...

Date of first consultation regarding this ailment - ……...

Name & the address of doctor who was first consulted - ……..

Period of Hospitalization

From…… To……

General Information-

If You are undergoing treatment for the Injury or Illness to which this claim relates. (Please state.)

Nature of Illness - ……..

Nature of Treatment - ……..

Name of Hospital concerned if any - ……..

Name of any consulting Specialists - ……..

P.T.O

Please Forward -

Original receipts for all payments
Original detail Bill
Diagnosis Card
Fully Completed claim form

I hear by declare that I have received the injuries above described and suffering from illness as above described and I claim reimbursement under the above scheme respect thereof I hereby warrant that the above statements and facts are true and that I have not withheld from the any material information connected with this claim. I merely bear the responsibility of the details given.

Witness - …… Signature ……

Date - …… Date …..……..

TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTIONER/CONSULTANT

Name of Patient (In full) - ……..…….

Condition that necessitated investigation or treatment - ……..

General practitioner by whom referred - …….……....

Diagnosis of disease - ……...

Details of treatment or operation and prognosis - ……...

Was the onset of illness acute, sub-acute or chronic? - ……

For how long the patient would have suffered from these symptoms and signs? - ……..

Please mention whether the patient is hospitalized or not,

Yes ☐ No ☐

If yes, pls provide followings,

Period of Hospitalization ..…… Date of admission …….

Date of Discharge……

State approximately when, in your opinion the ailment could have BEGUN or been CONTRACTED by the patient

I certify that I am the General Practitioner /Surgeon /Consultant of the patient of the referred to above, and that I approved the services for which this claim is made.

Name of the practitioner/Surgeon/Counsulant……

Qualification…….……

Address ……..

T.Phone No ……

…… **…….**

Date **Signature with the rubber stamp. Who attended.**

on this patient for this ailment