## **DELHI DEVELOPMENT AUTHORITY**

App	iicatioi	Homitor submitting claim to	spi, critoriic disease/po	ost operative.				
1.	Med	dical Card No.						
2.	Nan	Name of Pensioner/Family Pensioner/official						
3.	Nan	ne of spl. chronic disease	)					
	Spe	cify the operation (for post of	pperative)					
4.	Amo	ount of Claim						
5.		Please attach, statement of vrs, original Cash Memo & prescription.						
6.	Peri	od of medicine claimed :						
	a)	Previous claim:	to	on				
	b)	This Claim :	to					
4. 5. 6.	It is certified that all medicines purchased before this claim have been consumed by me in accordance with prescription.  Doctor's certificate (Essentiality certificate) is appended.  I also undertake that I will, without any demur, refund forwith to DDA, the amount, if any found inadmissible on detailed scrutiny/audit subsequently.  I am liable to face any action, if taken by DDA on A/c of false/inadmissible claim including disciplinary action.							
	Plea	Please, make payment through my following bank account						
	A/c l	No	Bank Name					
	IFSC	C Code :						
			Signature: _					
			Name : _					
			Phone: _					
			Address:					

## Detail /Statement of all Vouchers of OPD Claim for Rs.....

S. No.	Date	Cash Memo/Receipt No. & Date	Name of Doctor/Hospital/Lab	Amount
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			THE REPORT OF THE PARTY OF THE	
		CACTORIA STATE		
			Total Amount	Rs.

	Total Amount	Rs.
	Sig. of the cla	imant.
33/16-17/User-3	Name	