Claim No. _______________

____
(Name of Hospital)

VETERANS HOSPITALIZATION PROGRAM
REQUEST FOR REIMBURSEMENT FORM

Date: ____________________

THE DIRECTOR
Veterans Memorial Medical Center
North Ave., Diliman, Quezon City

Madam:

Request reimbursement of expenses incurred during the confinement of the following veterans/dependents in this hospital

in the amount of:____ (_________________).
(Amount in Words) *(Amount in Figures)*

SUMMARY OF PATIENTS' BILL

PATIENT/S	VETERAN STATUS **RPV-WW II**-(WW II Veteran) **RPVD-WWII** -(WWII Dependent) **RPV-AFP**-(AFP Veteran); **RPVD-AFP**-(AFP Dependent)	PERIOD OF CONFINEMENT (Date of Admission & Discharge)	NO. OF DAYS	AMOUNT

Attached are the original copies of the documentary requirements.

___ Statement of Account/s (with date of Admission & Discharge) signed by the Billing Clerk and the Chief Accountant of the Hospital
___ Medical Certificate/s/Discharge Summary (indicating period of confinement)
___ Proof of Veteran Status (photocopy of PVAO ID or VMMC ID; PVAO Certificate)

Thank you.

Very truly yours,

____
Chief *of Hospital*