YOMA GROUP

Medical Claim Form

Employee Information	
Name:	
Position:	Entity name:
Date joined:	Department:
Mobile:	Email address:
Outpatient/ Inpatient	
Date of invoice:	
Hospital/clinic name:	Doctor:
Date of admission to hospital:	Date of discharge from hospital:
Claim amount (Kyats):	
Employee signature:	
Approval Note	
HR Manager Name:	Signature:
Finance Department Name:	Signature

Note: The medical bill and relevant medical documents will need to be attached.