**Form KBF 10A**

# KARUNYA BENEVOLENT FUND

## REIMBURSEMENT OF CLAIMS

### * CONSOLIDATED STATEMENT OF BILLS & VOUCHERS

(To be attached with Bills & vouchers)

| **Name of Govt. Hospital:** | | | **Name of Consulting Doctor:** | | |
|---|---|---|---|---|---|
| **Period of treatment** | | | **From** | | **To** |
| **Sl. No** | **Date** | **Name of Firm from which bill/voucher issued** | **Bill/ Voucher No.** | **Amount** | |
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| | | **Total** | | | |

**Place:**

**Date:** **(Seal)** **Signature of the Consulting Doctor**

*** Add more sheets if needed**