UNIVERSITY OF NAIROBI HEALTH SERVICES
DENTAL /SPECTACLE CLAIM FORM

CLAIMANT NAME…… PAYROLL NO……

COLLEGE…… GRADE……

TERMS OF SERVICE (Tick appropriate) Permanent ☐ contract ☐ Temporary ☐

YEAR OF CLAIM……

I wish to apply for refund of the enclosed dental / spectacle expenses amounting to Khs…….....in respect

of Self / dependant, If dependants give the following information:

FULL NAME	**AGE**	**RELATIONSHIP**
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Treatment date:……

Hospital:……

Treatment Type (Tick appropriate): Dental ☐ Spectacles ☐

Signature…….. Date……

RECOMMENDATION BY HEAD OF DEPARTMENT

I confirm that the applicant is working in the Department of.....

As..... Grade.....

Signed..... Designation..... Date.....

APPLICANT SUBMISSION DATE

Submission date to UHS Accounts Office.....

Note: **Claims submitted three months after incurring the expenditure will not be admissible for reimbursement**

MEDICAL CLAIM

ANNEXES OF ADDITIONAL RECEIPTS FOR MEDICAL CLAIM

Analysis of the amount claimed

	CLAIMANT:	**PAYROLL NO:**
	COLLEGE:	**DESIGNATION:**

	RECEIPT DATE	RECEIPT NO.	DETAILS	AMOUNT