CENTRAL GOVERNMENT HEALTH SCHEME

CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. and place of issue :
2. Validity of CGH Card (For pensioners)& : from……to…….
   Entitlement : Pvt. / Semi Pvt. / General
3. Full name of Card Holder (Block Letters) :
4. Status (Govt. Servant / Pensioner / Other) :
5. The following documents are submitted :
   {Please tick (-/) the relevant column}

(a)	Medical 2004 Form		:	Yes / No
(b)	Photocopy of CGHS card		:	Yes / No.
(c)	Essentiality Certificate		:	Yes / No
(d)	No. of Original Bills		:	……
(e)	Whether original bills / vouchers have been verified		:	Yes / No.
(f)	Copy of discharge summary		:	Yes / No.
(g)	Copy of Permission letter		:	Yes / No.
(h)	Whether the hospital has given breakup for lab investigations		:	Yes / No.
(i)	Original papers have been lost the following documents are submitted—			
	I.	Photocopies of claim papers	:	Yes / No
	II.	Affidavit on Stamp Paper	:	Yes / No.
(j)	Incase of death of card holder the following documents are submitted----			
	I.	Affidavit on Stamp paper by Claimant	:	Yes / No.
	II.	No objection from other legal Heirs on Stamp papers	:	Yes / No.
	III.	Copy of death certificate	:	Yes / No.

Dated:……..

Signature of CGHS card holder

Tel. No. (O)

(R)

e-mail Address

Name of the Bank ……. …… Branch……..SB A / C No.

Branch MICR Code …….. Tel. No. of Bank Branch……..

CENTRAL GOVERNMENT HEALTH SCHEME
MEDICAL 2004 FORM FOR REIMBUREMENT OF MEDICAL CLAIMS OF CGHS BENEFICIARIES.

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Computer No.

(To be filled by the claimant**)**

1. CGHS Token No. and Place of issue :
2. Validity of CGHS Token Card : from……to……
   & entitlement : Pvt. / Semi Pvt. / General
3. Full name of the card holder (Block Letters) :
4. Full address :

5. Telephone no. (O)…… (R) ……..
6. E-mail address if, any.
7. Name of the Bank ……. …… Branch……SB A / C
   Branch MICR Code …….. Tel. No. of Bank Branch……..
8. Name of the patient & relationship
   with the card holder :
9. Status tick (-/) (Govt. Servant / Pensioner / Serving employee or pensioner of autonomous body / Member of Parliament / Ex-M.P. / Ex-Governor / Former Judge of Supreme Court / Former Judge of High Court / Freedom Fighter / Legal Heir / others)
10. Basic Pay / Basic Pension
11. Name of the Hospital with Address:
    (a) OPD treatment and investigations.

    (b) Indoor Treatment.

12. Date of admission……..Date of discharge…….(In case of Indoor Treatment only)
13. Total amount Claimed
    (a) OPD Treatment.
    (b) Indoor Treatment.

14. Details of Permission :
15. Details of Medical advance if, any:

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependant on me. I am a CGHS beneficiary and the CGHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated: Signature of CGHS card holder

Note: Misuse of CGHS facilities is a criminal offence. Suitable action including cancellation of CGH card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.

INFORMATION

a) Kindly write correct postal address in block letters

b) Obtain Break up of Investigations from the hospital (details and rates of individual tests and the exact number of Sugar tests, X-ray films, etc.,) as the reimbursable amount is calculated as per approved rates only.

c) Draft against column (I) of check list – in case of loss of Original Papers

Draft for Affidavit for Duplicate Claim Papers / bills on Stamp Paper

I, …….son / wife / daughter of …….and resident of lost / misplaced / not traceable. I hereby give an undertaking that I have not received any payment against original bills / claim papers from any source and that if the original papers are traced I shall not stake claim against original bills in future and that in the event I receive any cheque against original bills in future I shall return the same to competent authority.

Deponent

Verified by Notary Public

d) Draft against column (I) of check list-in case of Death of Card holder

Draft for Affidavit on Stump Paper for claiming medical reimbursement

I, ……wife / son / daughter of Late……..and resident of ……hereby submit the medical claim papers pertaining to treatment of my father / mother / ……Late Shri / Smt……..who has expired on……(copy of Death Certificate is enclosed).

Late Shri / Smt……..has left behind the following other legal heirs none of whom have any objection if the entire amount reimbursable is paid to me.

…….

…….

No Objection Certificate signed by other legal heirs on Stamp paper is enclosed herewith.

Deponent

Deponent

Attested by Notary Public

Draft for No Objection Certificate on Stamp Paper.

We……s / o d / o Late Shri……..

……s / o d / o Late Shri……...

being the legal heirs of Late Shri……have no objection if the entire amount reimbursable pertaining to the treatment of our father is paid to our brother Shri…….

( ) ( )

Address W / o

Address

Verified by Notary Public

Essentially Certificate-cum-statement of expenditure certified by treating specialist (to be submitted in duplicate)

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(Strike out whichever is not applicable)

1. Name of the patient and relationship with the card holder :-

2. Details of expenditure:

(A) OPD Treatment Diagnosis

(I) Name of the Hospital :
(II) Total No. of vouchers:
(III) Amount claimed.

(indicate serial number of individual vouchers with name and address of the shops with date against each sub heading in a separate annexure wherever required).

		(Amount claimed	Amount admissible (for official use.)
(a)	Medicine	----------	----------
(b)	Consultation Fees (specify number of consultations.)	----------	----------
(c)	Laboratory Charges (Break-up in a separate annexure.)	----------	----------
(d)	Disposable Surgls-Sundries.	----------	----------
(e)	Special devices like hearing aid / Artificial appliances etc. (Specify).	----------	----------
(f)	Miscellaneous (Specify)	----------	----------
	Total.	----------	----------

(B) Indoor Treatment Diagnosis_____

(To be marked N.A. wherever necessary).

(Details of Hospital Bill and other vouchers pertaining to the period of indoor treatment).

(a) Name of the Hospital with address :

(b) Period of Bill : From_____To_____

(b) Amount claimed,
(Indicate serial No. of individual vouchers with name and address of shops with date against each sub heading in a separate annexure wherever required).

	Amount Claimed.	Amount Admissible (for Office use)
(i) Room Rent :- ICU / ICCU / Ward From___TO_____	_____	_____

(ii) Charges for :

(a)	O.T.	_____	_____
(b)	O.T. Consumables	_____	_____
(c)	Anesthesia	_____	_____
(d)	Procedure	_____	_____
(iii)	Medicines	_____	_____
(iv)	Implants like pacemaker joint replace-Ment, Coronary Slent etc. (details).	_____	_____
(v)	Artificial devices (details)	_____	_____
(vi)	Lab charges. (Break-up given in Annexure).	_____	_____
(vii)	Spl. Nurse / Aya If any	_____	_____
(viii)	Miscellaneous	_____	_____
	Total	_____	_____

Signature of Claimant
Name in Block Letters.
Address & Telephone No. if any.

1. Certificate that the relevant bills / vouchers have been verified by me and the expenditure shown above is correct and the treatment services provided are essential and minimum that required for the recovery of the patient.
2. Certified that the services of special Nurse / Ary were required from_____To_____ that were absolutely essential for the recovery of the patient.
3. Specific procedure / Operation performed was_____.

Signature of the Treating Specialist

With official seal.

Countersigned by Medical Superintendent
of the Hospital with seal (For Indoor treatment only.)