G.I., M.H. & F.W., Letter No. Misc. 5/2004/R&H/CGHS/CGHS(P), dated 9-5-2004

PREFERRING OF MEDICAL CLAIMS BY CGHS BENEFICIARIES (both serving/pensioners) AND REIMBURSEMENT THEREOF

(Medical 2004 Form, Checklist and Essentiality-cum-Statement of expenditure certificate to enable the CGHS beneficiaries (both serving/pensioner) to prefer their medical claims for reimbursement from the Government)

CENTRAL GOVERNMENT HEALTH SCHEME

CHECKLIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. and place of issue : ....
   ....
2. Validity of CGH Card (*For pensioners*) and entitlement : from..... to ..... Pvt./Semi Pvt./General
3. Full name of Card Holder (*Block Letters*) : .....
4. Status (Government 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 break-up for lab investigation : Yes/No
   - (*i*) Original papers have been lost, the following documents are submitted—
     - *I.* Photocopy of claim papers : Yes/No
     - *II.* Affidavit on Stamp Paper : Yes/No
   - (*j*) In case of the 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 Paper : Yes/No
     - *III.* Copy of death certificate : Yes/No

Dated :.....

Signature of CGHS card holder/claimant

Tel. No. *(O)* ..... *(R)* .....

e-mail Address.....

Name of the Bank .....

Branch .....

S.B. A/c No.....

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF CGHS BENEFICIARIES

COMPUTER NO. :

(To be filled by the claimant)

1. CGHS Token No. and Place of issue ... : .....

   .. ..

2. Validity of CGHS Token Card .. ... : from..... to .....
   and entitlement .. ... Pvt./Semi Pvt./General

3. Full name of Card Holder .. ... : .....
   (*Block Letters*)

4. Full Address .. ... : .....

   .. ..

5. Tel. No. .. ... : (O) .....

   .. ... : (R).....

6. e-mail Address, if any .. ... : .....

7. Name of the Bank .. ... : .....

   Branch .. ..:

   S.B. A/c No .. ... : .....

8. Name of the patient .. ... : .....

   & relationship with card holder .. ... : .....

9. Status tick (✓) (Government 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)

—Cond-2

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 dependent 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/claimant

***Essentiality Certificate**-cum-statement of expenditure certified by treating specialist (to he submitted in duplicate).*

(Strike out whichever is not applicable)

1. Name of the patient and relationship with 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 Surgi-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 and other vouchers pertaining to the period of indoor treatment)

(a) Name of the Hospital with address: .....

: .....

(b) Period of Bill : from..... to .....

(c) 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)
(*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 replacement, Coronary stent, etc. (*details*)	:	....
....		
....		
(*v*) Artificial devices (*details*)	:	....
....		
(*vi*) Lab charges (*Break-up given in Annexure*)	:	....
....		
(*vii*) Special Nurse/Ayah, if any .	:	....
(*viii*) Miscellaneous	:	....
Total	:	....

Signature of Claimant ....

Name in Block Letters ....

Address ....

....

Telephone No., if any ....

1. Certified 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 is required for the recovery of the patient.
2. Certified that the services of special Nurse/Ayah 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*)~~

MEDICINE

Annexure I

Sl.No.	Bill No.	Date	Name of the Shop	Address of the Shop	Amount

LABORATORY CHARGES

Annexure II

Sl.No.	Bill No.	Date	Name of the Lab	Address of the Lab	Amount