ANNEXURE I

CENTRAL GOVERNMENT HEALTH SCHEME

MODIFIED 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) No. of Original Bills : .....
(d) Copy of discharge summary : Yes/No.
(e) Copy of referral by Specialist /CMO : Yes/No.
(f) Whether the hospital has given breakup for lab investigations : Yes/No.
(g) Original papers have been lost the following documents are submitted—
   I. Photocopies of claim papers : Yes/No
   II. Affidavit on Stamp Paper : Yes/No.
(h) 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 Referral :
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)