FORM – MRC (P)

(*For pensioner beneficiaries*)

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled by the Principal Card holder/Claimant in **BLOCK LETTERS**)

1. (a) Name of the Principal CGHS Card Holder :
   (b) CGHS Ben ID No. :
   (c) CGHS Wellness Center to which the card is attached :
   (d) Validity of CGHS Card :
   (e) Ward Entitlement – Pvt./Semi-Pvt./General :
   (f) Full Address :

   (g) Mobile telephone No. and e-mail address, if any :
2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal CGHS card holder :

3. Category of pensioner beneficiary - please specify :
   (Central Govt. Pensioner/Pensioner of Autonomous/Statutory body/Ex- MP/ Ex-Governor/ Former Judge of Supreme Court/ Former Judge of High Court/Freedom Fighter/Legal Heir/Others)

4. Name & address of the hospital / diagnostic center / imaging center where treatment is taken or tests done:

5. Whether the hospital/diagnostic/imaging center is empanelled under CGHS : Yes/No

6. Treatment for which reimbursement claimed
   (a) OPD/Test & investigations :
   (b) Indoor Treatment :
7. Whether credit facility was availed. If not, reasons thereof (clarification may be attached) :

8. Whether treatment was taken in emergency : Yes/No

9. Whether prior permission was taken for the treatment : Yes/No

10. Whether subscribing to any health/medical insurance : Yes/No
    scheme, If yes, amount claimed/received :
11. **Total amount claimed** :
    (a) OPD Treatment :
    (b) Indoor Treatment :
    (c) Tests/Investigation :
12. Name of the Bank :..... SB A/c No.: .....
    Branch MICR Code: ..... IFSC Code.....

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.

Date: .....

Place: ..... **Signature of the Principal CGHS card holder / Claimant**

NATIONAL BOOK TRUST, INDIA VASANT KUNJ, NEW DELHI

Modified Check list for Reimbursement of Medical Claims

1.	CGHS Token No. and Place of issue (or Beneficiary ID No. of Employee/Pensioner)		
2.	Validity of CGHS Card		
3.	Entitlement of Ward (Pvt./Semi-Pvt./General)		
4.	Full name of the Principal Card Holder		
5.	Full name of Patient and relationship with the Principal Card holder		
6.	The following documents are submitted:-		
	(a)	Medical Form - 2004 (Revised)	
	(b)	Photocopy of CGHS Card	
	(c)	No. of Original Bills	
	(d)	Copy of Discharge Summary	
	(e)	Copy of Referral Specialist/CMO	
	(f)	Whether the hospital has given break-up for lab Investigations	
	(g)	Original papers have been lost the following documents are submitted:- i.) Photocopies of claim papers ii.) Affidavit on Stamp paper	
	(h)	In case of death of card holder the following documents are submitted:- i.) Affidavit on Stamp Paper by claimant ii.) No objection from other legal heirs on stamp papers iii.) Copy of Death Certificate	

Date:
Place

Signature of the Principal CGHS Card Holder
Mobile No. –
Telephone No. (Office)
(Residence)

Name of the Bank: ..... Branch: ..... Saving Bank Account No.: .....

Branch MICR Code: ..... IFSC Code: ..... Telephone No. of Bank Branch: .....

Proforma No. – 1

UNDERTAKING

I _____ (Name, Designation and Contact No.) solemnly affirm that my husband/wife Shri/Smt. _____ (Name, Designation and Contact No.) has been working in the office/ministry _____ (Name, Address and landline No.). He/she has not preferred any Medical Claim from his/her department in respect of self or family or both.

I further undertake that he/she has not been paid medical allowance from his/her office.

The above information is given to the best of knowledge and belief. I am aware that in case the information is found false at any stage, I can be prosecuted under CCS (CCA) Rules 1965 as amended from time to time.

Signature _____

Name _____

Designation _____

Date _____

Documents to be attached

1. Photo copy of the CGHS card of the principal card holder along with the patient's CGHS Card.
2. Copy of permission letter, if any.
3. Emergency certificate (original), in case of emergency.
4. Copy of the discharge summary.
5. Ambulance Certificate (original), if any.
6. Original bills /cash memo / vouchers etc. for the reimbursement amount claimed.

IMPORTANT

Kindly ensure to provide the following information / documents, wherever applicable:

a) Obtain Break up of Investigations from the hospital/diagnostic center/imaging center (details and rates of individual tests and the exact number of tests, X-ray films, etc.,) as the reimbursable amount is calculated as per approved rates per test.

b) In case of loss of original papers, Affidavits as per Annexure I to be submitted. All photocopies of the bills to be attested by the treating doctor/specialist.

c) In case of death of the card holder, Affidavit as per Annexure II to be filled and attached to claim reimbursement,

c) In case of implants, Invoice No. along with sticker with serial number of the implant to be attached.

d) In case of Coronary Stents, outer pouch of stents is to be enclosed.

e) In case of replacement of pacemaker / ICD etc., copy of the warranty certificate of earlier pacemaker /ICD may be enclosed.

Note: Misuse of CGHS facilities is a criminal offence. Penal action including cancellation of CGHS card may be taken in case of willful suppression of facts or submission of false claims / statements.

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NATIONAL BOOK TRUST, INDIA

Nahru Bhawan, 5, Institutional Area, Phase-II,
Vasant Kunj, New Delhi-110070

CASH / BANK / JOURNAL VOUCHER

(From Sholu be Filled in Capital Letter Only)

EMP/PARTY/OTHER CODE | | | | | | | TA/DA/MISC.ADV REGISTER PAGE No. | |

CANARA BANK SB A/C | | | | | | | | | | | | | | SL.No. | |

1. NAME .....

2. ADDRESS .....

.....

3. BILL NO. & DATE : .....

4. PARTICULARS : .....

5. RUPEES (IN FIGURES) | | | | | | | | | |

6. RUPEES (IN WORDS) .....

Rev. Stamp

Signing on Revenue Stamp is mandatory for all payment above Rs.5000/-

(SIGNATURE OF CLAIMANT)

NOT PAID EARLIER. CLAIM IS IN ORDER AND RECOMMENDED FOR PAYMENT.

ECR & STOCK ENTRY HAVE BEEN MADE AND CERTIFIED

(DEALING ASSISTANT) **(SUPERVISOR)** **SECTIONAL IN-CHARGE/HEAD**

FOR OFFICE (A/CS USE ONLY)

BROAD HEAD:	N-Plan	Plan	ADHOC
DEBIT HEAD CODE:	1	2	3
CREDIT HEAD CODE			

CASH	BANK	JOURNAL
Rs.		
Rs.		
Rs.		
Rs.		
Rs.		
Rs.		
Rs.		

7. PAY ORDER : .....

(DEALING ASSISTANT) **(ACCOUNTANT)** **(AUTHORISED SIGNATORY)**

CASHIER