**EMPLOYEE HEALTH SCHEME**
**MEDICAL REIMUBRSHMENT CLAIM FORM**
**(To be filled up by the EHS Card holder in BLOCKLETTERS)**

**1. Details of EHS beneficiary.**

(a) Name of the EHS card Holder-

(b) Employee ID Number-

(c) EHS Card Number-

(d) Ward Entitlement–Pvt.☐ /General-☐

(e) Mobile number -

(f) E-mail ID-

(g) Full Address-

**2. Details of the Person for which claim has been demanded.**

(a)Patient's name-

(b) Patient's EHS Number–

(c)Relationship with the EHS Cardholder-

**3. Name & address of the hospital/diagnostic center/**

**Imaging center where treatment has been received.**

| Sl. No | Name Of Hospital/Lab/Imaging centre | Address |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**4. Treatment for which reimbursement claimed-**

(a) OPD Treatment ☐ (b) IPD Treatment ☐ (c) Medical Bill ☐ (d) Vaccination ☐

Others (Specify)- _____

**5. Whether treatment was taken in emergency from outside Hospital -** Yes/No

**6. Whether prior permission was taken for the Emergency treatment-** Yes/No

(If yes, attach appropriate document as per checklist)

**7. Whether subscribing to any health/medical Insurance Scheme-** Yes/No

if yes amount (claimed /received)

☐ Claimed Rs_____ ☐ Received Rs_____

**8. Details of Medical Advance taken, if any-**

**9 .Amount Claimed-**

| S.no | Treatment | Particular | | | Cost | Conversion of Outside Bill as per CGHS rate (For office use) |
|---|---|---|---|---|---|---|
| A | OPD | Drugs Test | | | | |
| | | Lab Test | | | | |
| | | Imaging Test | | | | |
| | | **Total Amount OPD** | | | **Rs** | **Rs** |
| B (1) | IPD (Part A) | Bed Charges | Ward Type | No of Days | Cost | Cost Conversion of Outside Bill as per CGHS rate (For office use) |
| | | | General Ward | | | |
| | | | Private Ward | | | |
| | | | HDU | | | |
| | | | ICU | | | |
| | | | Others | | | |
| | | | Total Days | | ———— | ———— |
| B (2) | IPD (Part B) | Drugs | | | | |
| | | Lab Tests | | | | |
| | | Imaging Tests | | | | |
| | | O.T Charges | | | | |
| | | Others | | | | |
| | | **Total Amount IPD** | | | **Rs** | **Rs** |
| C | Vaccination | Detail of vaccination taken | | | Cost | Conversion of Outside Bill as per CGHS rate (For office use) |
| | | 01. | | | | |
| | | 02. | | | | |
| | | 03. | | | | |
| | | 04. | | | | |
| | | **Total Amount Vaccination** | | | **Rs** | **Rs** |
| D | Medical Bill | Name of Test done | | | Cost | Conversion of Outside Bill as per CGHS rate (For office use) |
| | | 01. | | | | |
| | | 02. | | | | |
| | | 03. | | | | |
| | | **Total Amount Medical Bill** | | | | |
| E | Others/Emergency | Specify | | | Cost | Conversion of Outside Bill as per CGHS rate (For office use) |
| | | 01. | | | | |
| | | 02. | | | | |
| | | 03. | | | | |
| | | **Total Amount Others** | | | **RS** | **RS** |
| | **Total Amount Claimed** | | | | | ———— |
| | **Total Reimbursement Amount** (As Per Norms) (For Office Use) | | | | ———— | |

**10. Employee's Bank Detail's (Salary Account Only)**

(1)A/C holder Name…….. (2)Salary A/C Number……

(3)Bank Name…… (4)IFSC Code……..

(5)Branch…… (6)MICR 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 was me or is dependent on me. I am an EHS beneficiary, and the EHS card was valid at the time of treatment. My monthly EHS contribution is deducted from my salary .I agree to the reimbursement as in admissible under the rules.

Date……

Place…… Signature of the EHS Card Holder

## For EHS Office Use Only

**11. Verification by EHS Cell.**

| | | |
|---|---|---|
| LDC/UDC | Sign | |
| | Date | |
| | Designation | |
| Member EHS from Pharmacology/Pharmacist | Sign | |
| | Date | |
| | Designation | |
| Member EHS from Pathology/In charge | Sign | |
| | Date | |
| | Designation | |
| Member EHS from Radiology/Other dept. | Sign | |
| | Date | |
| | Designation | |
| EHS Chairperson | Sign | |
| | Date | |
| | Designation | |

## For Administrative Use Only

**12. Approval from Administrative Section DDA/AO.**

Mr./Miss /Mrs. /Dr._____ is an active EHS member whose EHS ID No is_____.The Claim of the verified amount Rs_____is put on for your kind perusal.

Date…….

Sign & Seal
DDA /AO.

## For Account Section Only

**13.Approval from Account Officer –**

The EHS Beneficiary Claim of the verified amount Rs _____ is to be transferred from EHS AIIMS Deoghar A/C to Employee Salary A/C.

Sign & Seal
Account Officer.

**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 and the exact number of tests, X-ray films, etc.) as the reimbursement amount is calculated as per approved CGHS/AIIMS Rates per test.
B. In case of loss of original papers, Affidavits as per Annexure I to be submitted. AH 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.
D. In case of implants. Invoice No. along with sticker with serial number of the implant to be attached.
E. In case of coronary Stents, outer pouch of stents is to been closed.
F. In case of replacement of pacemaker/1CDetc.copy of the warranty certificate of earlier pacemaker/ICD may be enclosed.

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## Annexure-I

### Draft for Affidavit for duplicate Claim papers bills on stamp paper

I,.....son/wife/daughter of..... and resident of

..... misplaced/lost the original paper

Or the same is not traceable.

I hereby give an undertaking that I have not received any payment against the original bills/claimed paper from any source, and that if the original papers are traced. I shall not stake claim against original bills in the future and that in the event, I receive any cheque against the original bills in the future, I shall return the same to competent authority.

Signature

Verified by Notary public

## Annexure-II

**Draft for Affidavit on Stamp Paper for claim medical reimbursement**
**IN CASE DEATH OF A EHS CARD HOLDER**

I…….Husband/Wife/Son/Daughter of late and resident of ……here by submit the medical reimbursement claim pertaining to the treatment of my husband/wife/father/mother late shri/smt who has expired on. (A 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 reimbursement amount is paid to me.

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

Deponent.

Attested by Notary Public.

## Draft for No Objection Certificate to Stamp paper-

(I) We_____S/O,_____D/O_____
late Shri_____
(II) S/o_____ D/o _____
late Shri _____
(III) _____
(IV) _____
_____ Being the legal heir of Late Shri/Smt_____have no Objection if the entire amount reimbursable pertaining to the treatment of late Shri/Smt_____is paid to Shri/Smt_____

(i) Signature-
Name-
Address-

(II) Signature-
Name-
Address-

(III) Signature-
Name-
Address-

Verified by Notary Public