CENTRAL GOVERNMENT HEALTH SCHEME
MODIFIED CHECKLIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. & place of issue: _____
2. Validity of CGHS Card (for pensioners) & Entitlement: from _____ to _____
3. Full Name of Card Holder (Block Letters): _____
4. Status (Govt. Servant/Pensioner/Others): _____
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) In case 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): _____

Tel. No. (R): _____

E-mail: _____

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 REIMBURSEMENT OF MEDICAL CLAIMS OF CGHS BENEFICIARIES

(To be filled by the claimant)

1. CGHS Token No. & place of issue: _____
2. Validity of CGHS Card (for pensioners): from _____ to _____

   & Entitlement, please tick (√) : Pvt. Ward / Semi Pvt. Ward / Gen. Ward
3. Full Name of Card Holder (Block Letters): _____
4. Designation & Emp. Code of the Card Holder: _____
5. Full Address:_____

   _____
6. Telephone No.: (O) _____ (R) _____
7. E-Mail Address, if any: _____
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-MP / Ex-Governor / Former Judge of Supreme Court / Former Judge of High Court / Freedom Fighter / Legal Heir / others)
10. Basic Pay/Basic Pension: Rs. _____
11. Name of the Hospital/Diagnostic Centre 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: Rs. _____

    (b) Indoor Treatment: Rs. _____
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 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)

<u>NOTE</u>: Misuse of CGHS facilities is a criminal offence. Suitable action including cancellation of CGH card shall be taken in case of willful suppression or submission of false statements. Suitable discipilinary 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 reimbursement 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

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

I, ..., son/wife/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.

Deponent

Attested by Notary Public

.....

Draft for No Objection Certificate on Stamp Paper

We, ... s/o / d/o Late Shri/Smt ..... , ... s/o / d/o Late Shri/Smt ..... being legal heirs of Late Shri/Smt ..... have no objection if the entire amount reimbursable pertaining to the treatment of our father is paid to our brother Shri .....

(.....) (.....)

Address Address

Deponents

Verified by Notary Public