CENTRAL GOVERNMENT HEALTH SCHEME
CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. and place of issue :

2. Validity of CGHS Card from.....to.....

3. Entitlement Pvt./Semi Pvt/General

4. Full name of the Card Holder (in Block Letters) :

5. Status (Govt.servent/Member of Parliament) :

6. The following documents are submitted : (Please tick(√) the relevant column)

(a)	Medical 2004 Form	:	Yes/No
(b)	Photocopy of CGHS card	:	Yes/No
(c)	Photocopy of permission letter	:	Yes/No
(d)	No. of Original Bills	:	.....
(e)	Copy of prescription	:	Yes/No
(f)	Copy of discharge summary	:	Yes/No
(g)	Copy of referral by Specialist/CMO	:	Yes/No
(h)	Whether the hospital has given breakup: for lab investigations		

(i) Original papers have been lost & the following documents are submitted –

I.	Photocopies of claim papers	:	Yes/No
II.	Affidavit on Stamp Paper	:	Yes/No.

(j) 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 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.....

   Entitlement : Private/Semi Private/General

3. Full name of the card holder (in Block Letters) :

4. Full address :

5. Telephone no
   (O).....(R).....(M).....

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 pension of autonomous body/Member of Parliament/Ex-MP/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 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 the Member:**.....

Name: .....

IC No.:.....

Note: Misuse of CGHS facilities is a criminal offence. Suitable action including cancellation of CGHS 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 (Annexure-I)**

d) **Draft against column (I) of check list-in case of Death of Card holder (Annexure-II)**

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper (Annexure –I)

I,.....son/wife/daughter of.....and resident of ..... lost/misplaced the original paper or the same are 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. If I receive any cheque against original bills in future I shall return the same to competent authority.

Deponent
Verified by Notary Public

Draft for Affidavit on Stamp Paper for claiming medical reimbursement (Annexure-II)

I,.....husband/wife/son/daughter of Late.....and resident of .....hereby submit the medical claim papers pertaining to treatment of my husband/wife/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

Deponent
Attested by Notary Public

Draft for No Objection Certificate on Stamp Paper.

We (i).....S/o D/o Late Shri.....
(ii)..... S/o D/o Late Shri.....
(iii)..... S/o D/o Late Shri.....
(iv))..... S/o D/o Late Shri.....

being the legal heirs 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)	(ii)(Signature)	(iii) (Signature)	(iv) (Signature)
Name:	Name	Name:	Name
Address:	Address:	Address	Address

Verified by Notary Public