ANNEXURE-I

DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME
MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. DGEHS Card No. and Place of Issue

2. Validity of DGEHS Card from ..... to .....

3. Ward Entitlement (if Admitted in Hospital) Private. / Semi Private. / General

4. Full Name of Employee (Block Letters):- Mr./Ms.

5. Designation:-

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

a) Revised Medical 2004 Form:- Yes/No

b) Photocopy of DGEHS Card showing validity (Emp. /Patient): - Yes/No

c) Photocopy of Referral/ Authorization from AMA:- Yes/No

d) Original Bills: - Yes/No

e) Copy of prescription for OPD cases / Discharge Summary for Indoor cases:- Yes/No

f) Breakup for Lab Investigation:- Yes/No

g) Breakup of Drugs prescribed:- Yes/No

h) Emergency Certificate from Hospital Empanelled / Registered with Government in case of Emergency Admission: - Yes/No

i) Self explanatory letter showing the need of emergency visit (in emergency cases): - Yes/No

j) Non Availability Certificate from AMA (attached Dispensary / Hospital) for drugs prescribed in OPD's :- Yes/No

k) Original papers have been lost the following Documents are submitted: - Yes/No
   i. Photocopies of Claim Papers:- Yes/No
   ii. Affidavit on Stamp Paper: - Yes/No

l) In case of Death of Card Holder the following Documents are submitted:- Yes/No
   i. Affidavit on Stamp Paper by Claimant: - Yes/No
   ii. No objection from other legal Heirs on Stamp paper :- Yes/No
   iii. Copy of Death Certificate:- Yes/No

7. Name of the Bank ..... Branch ....SB A/C No. .....
Branch MICR Code.....IFS Code. ..... Tel. No. of Bank Branch.....

Dated:- **Signature of DGEHS Card Holder**

Telephone No. (M)..... (O).....E-Mail ID:-.....

Note: - 1. Kindly enclose Photocopy of Cancelled Cheque for online transfer of many to the account of beneficiary.
2. Provide one original copy and two photocopies of complete set of claim.

Note:- Please clearly fill mentioned details:-

Employee Pin:-

Mobile Number:-

Place of posting:-

ANNEXURE-II

DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME REVISED MEDICAL 2004
FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF DGEHS BENEFICIARIES

(To be filled by the claimant)

1. DGEHS Card No. and Place of issue:-
2. Validity of DGEHS Card: - from ..... to .....
3. Ward Entitlement (if Admitted in Hospital) : - Private. / Semi Private. / General.
4. Full Name of Employee (Block Letters) :-

5. Full Address :-

6. Telephone No. (O)..... (M) .....
7. E-mail Address if, any :-

8. Name of the Bank, ...,.....Branch ..... SB A/C No.....

Branch MICR Code.....IFS Code..... Tel. No. of Bank Branch.....

9. Name of the Patient & Relationship with the Card Holder:-
10. Basic Pay (Excluding Grade Pay) :-
11. Name of the Hospital with Address:-

(a) OPD Treatment (Investigations) & Period of treatment:-

(b) Indoor Treatment:- Date of Admission ..... Date of Discharge.....

12. Total Amount Claimed: - Total Rs.

Total amount claimed ₹	Consultation Charges	Investigation Charges	Medicine Charges	Other Charges
For OPD Treatment				
For Indoor Treatment				

13. Details of Referral:-

14. 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 DGEHS beneficiary and the DGEHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated:-

Signature of DGEHS Card Holder

Note: Misuse of DGEHS facilities is a criminal offence. Suitable action including cancellation of DGEHS 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.