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.

S.no	Hospital Name	Lab	Imaging center	Address

4. Treatment for which reimbursement claimed (Tick [✓] the appropriate box)-

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

(e)Casualty Treatment ☐ (f)Others (Specify)- _____.

5. Whether treatment was taken in emergency- Yes/No

6. Whether prior permission was taken for the treatment- Yes/No
(If yes, attach appropriate document as per checklist)

7. Whether reimbursing from any other 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 Account office use Purpose)
A	OPD	Drugs				
		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 Test Bill (APAR related)	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 Account Office Use Purpose)				_____	

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……

11.Declaration by the Primary EHS Card Holder:

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

12.**Declaration by the treating Consultant:**

I Dr…… hereby certify that the patient has been under treatment at …… Hospital, …….. , ……..

And that the medicine(s)/investigation(s) prescribed by me in this connection were essential for the recovery / prevention of deterioration of the patient's condition. I hereby declare that I have **personally verified all the submitted bills** related to **medicines and investigations**, and they correspond to the prescriptions and diagnostic tests advised by me during the course of treatment. To the best of my knowledge, all the documents submitted for reimbursement are **genuine, appropriate, and medically justified**.

Sign, Date & Seal of Treating Physician & Surgeon

13. For EHS Office Use Only

Verification by EHS Cell.

Sign –
Date –
LDC/UDC Name –

Sign –
Date -
EHS Chairperson/ EHS
Member Name –
Designation -

14. For MS Office Use Only

Verification & Approval from MS Office.

Date…….

Sign & Seal
Medical Superintendent

15. For Administrative Use Only

Approval from Administrative Section DDA/AO.

Mr. /Mrs. /Dr._____ is an active EHS member whose EHS ID No is_____. The Medical Claim of the verified amount Rs_____ is submitted for processing of payment as per rule.

Date…….

Sign & Seal
DDA /AO.

16. For Account Section Use Only

Approval from Account Officer.

Date…….

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 be enclosed.
F. In case of replacement of pacemaker/1CDetc.copy of the warranty certificate of earlier pacemaker/ICD may be enclosed.

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 of medical reimbursement in case of 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

_____***_____

'Check List'

Checklist for Settlement of Medical Claim through EHS Cell.

- EHS Beneficiary should submit a filled-up application with supporting documents to EHS department for claiming reimbursement of medical expenditure and settlement of any advance within **06 (Six) months** of discharge from hospital / treatment taken.
- Claim settlements documents should be submitted through proper channel. Competent authority for settling claim will be **DDA and Account section.**

Application should be submitted along with the following documents-

✓ or ✗	Sl.No.	Particular
	1.	**Covering letter/** self-representation by beneficiary.
	2.	Duly filled **Medical Claim /Reimbursement Form (Which contains checklist & Master Invoice Sheet- Sl.No. 03 & 04)**
	3.	**Checklist Form** for reimbursement.
	4.	Summary of total medical bills claimed (**Master Invoice Sheet** showing total claim value, filled in chronological order, Format given on Last page of Reimbursement Form) **- (Mandatory).**
	5.	Photocopy of Valid AIIMS Deoghar Employee ID/ **Smart EHS card.**
	6.	**Photocopy of OPD Prescription** of treating medical officer along with Front Cover of EHS OPD Booklet/ **Discharge Summary** (For admitted patients)
	7.	**All the original bills (**attested by treating Consultant & EHS beneficiary**)** in chronological sequence. [EHS beneficiary must keep the photocopies of all the bills for his convenience].
	8.	Appropriately filled up, signed and sealed **E-DRF form - (Optional).**
	9.	Appropriately filled up, signed and sealed **E-ITRF form - (Optional).**
	10.	**Most recent payslip** showing deduction of EHS monthly contribution. - **(Optional).**
	11.	**In case, the treatment is taken in emergency;- (a+b+c), [SOS basis]**
		a. **Permission copy** of M.S/ Executive Director (if applicable) / Intimation copy to EHS Cell during emergency for approval of treatment outside.
		b. A **self-explanatory letter** from beneficiary, explaining emergency circumstances.
		c. **Emergency treatment certificate** from concerned hospital must also be submitted.
	12.	**Affidavit on stamp paper** by claimant, no objection from any or legal heirs on stamp paper and copy of death certificate, *in case of death of card holder.*
	13.	Photocopies of claim paper & affidavit on stamp paper *in case original papers have been lost.*
	14.	Bank details (**Salary Account Details** only) of EHS beneficiary on the specified space of Claim Reimbursement Form. (Attach photocopy of the cancelled Cheque of your salary account) **- (Optional).**
	15.	Utilization Certificate (**Implant related).**

7.

Master Invoice Sheet

This section is designated for summarizing the total medical bills claimed by the applicant and must be completed clearly in chronological order. After filling it out, the form should be verified by the treating consultant and self-attested by the applicant.

Master Invoice Sheet

Sl.No.	Bill Number	Bill Date	Bill Amount			
			In-house Bill Amt. (A)	Outside Bill Amt. (B)	CGHS rate of (B) [for Account Office Use Purpose] (C)	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
Total Bills			_____₹	_____₹	__ _____₹	
Aggregate Bill Amount =			_____₹			
Total Reimbursable Bill Amount (A + C) =. _____₹ *[for Account Office Use Purpose]*						

Note – Additional 'Master Invoice Sheet' may be added if required.

Sign, Date & Seal of Treating Physician / Surgeon

Sign & Date of EHS Card Holder