FORM – MRC (P)

(For pensioner beneficiaries)

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled by the Principal Card holder/Claimant in BLOCK LETTERS)

1. (a) Name of the Principal CGHS Card Holder :
   (b) CGHS Ben ID No. :
   (c) CGHS Wellness Center to which the card is attached :
   (d) Validity of CGHS Card :
   (e) Ward Entitlement – Pvt./Semi-Pvt./General :
   (f) Full Address :

   (g) Mobile telephone No. and e-mail address, if any :
2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal CGHS card holder :

3. Category of pensioner beneficiary - please specify :
   (Central Govt. Pensioner/Pensioner of Autonomous/Statutory body/Ex- MP/ Ex-Governor/ Former Judge of Supreme Court/ Former Judge of High Court/Freedom Fighter/Legal Heir/Others)

4. Name & address of the hospital / diagnostic center / imaging center where treatment is taken or tests done:

5. Whether the hospital/diagnostic/imaging center is empanelled under CGHS : Yes/No

6. Treatment for which reimbursement claimed
   (a) OPD/Test & investigations :
   (b) Indoor Treatment :
7. Whether credit facility was availed. If not, reasons thereof (clarification may be attached) :

8. Whether treatment was taken in emergency : Yes/No

9. Whether prior permission was taken for the treatment : Yes/No

10. Whether subscribing to any health/medical insurance scheme, If yes, amount claimed/received : Yes/No
11. **Total amount claimed**
    (a) OPD Treatment :
    (b) Indoor Treatment :
    (c) Tests/Investigation :
12. Name of the Bank :..... SB A/c No.: .....
    Branch MICR Code: ..... IFSC 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 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.

(Signature)

NATIONAL BOOK TRUST, INDIA VASANT KUNJ, NEW DELHI

Modified check list for reimbursement of medical claims

01	CGHS Token No. and place of issue (or Ben ID of Employee/Pensioner)	
02	Validity of CGHS Card	From.....to.....
03	Entitlement	Pvt. /Semi Pvt./General
04	Full name of Principal Card Holder	
05	Full name of patient & Relationship with the Principal Card Holder	
06	The following documents are submitted (Please tick (✓)I the relevant column)	
(a)	Medical 2004 Form (Revised)	Yes/No
(b)	Photocopy of CGHS Card	Yes/No
(c)	No. of original bills	s/ No
(d)	Copy of discharge summary	Yes/No
(e)	Copy of referral Specialist/CMO	Yes/No
(f)	Whether the hospital has given break up for lab investigations	Yes/No
(g)	Original papers have been lost the following documents are submitted – I Photocopies of claim papers II Affidavit on Stamp Paper	 Yes/No Yes/No
(h)	In case of death of card holder the following documents are submitted: I Affidavit on Stamp paper by Claimant II No objection from other legal Heirs on stamp papers III Copy of death certificate	 Yes/No Yes/No Yes/No

Date : ....
Place: ....

Signature of Principal CGHS Card holder
Tel. No. (O)
(R)

Name of the Bank .....Branch.....SB Account No. .....
Branch MICR Code .....Tel. No. of Bank Branch .....

Documents to be attached

1. Photo copy of the CGHS card of the principal card holder along with the patient's CGHS Card.
2. Copy of permission letter, if any.
3. Emergency certificate (original), in case of emergency.
4. Copy of the discharge summary
5. Ambulance Certificate (original), if any.
6. Original bills /cash memo / vouchers etc. for the reimbursement amount claimed.

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, X-ray films, etc.,) as the reimbursable amount is calculated as per approved rates per test.

b) In case of loss of original papers, Affidavits as per Annexure I to be submitted. All 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.

c) In case of implants, invoice No. along with sticker with serial number of the implant to be attached.

d) In case of Coronary Stents, outer pouch of stents is to be enclosed.

e) In case of replacement of pacemaker / ICD etc., copy of the warranty certificate of earlier pacemaker /ICD may be enclosed.

Note: Misuse of CGHS facilities is a criminal offence. Penal action including cancellation of CGHS card may be taken in case of willful suppression of facts or submission of false claims / statements.

Proforma-II

(Certificate applicable for Indoor Patient only.)

UNDERTAKING

*I..... .....(name , designation and contact no.) solemnly

Affirm that my husband/wife Shri/Smt..... (name, designation and

Contact no.) has been working in the office/ministry.....
(name, address and landline no.)./ I am a pensioner.

I further certify that I or my spouse is not covered with Medi-claim insurance scheme/ has not preferred any claim from such health insurance organization against the present medical bill.

The above information is given to the best of my knowledge and belief. I am aware

that in case the information is found false at any stage, I can be prosecuted under CCS (CCA) **Rules 1965/ Indian Penal Code**.

Date

Signature

Name
Designation

Residential

address.....

Contact No.....

- *Pl mark tick ( ) whichever is applicable.*

FORM – MRC (S)
(For serving employees)

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the Principal Card holder in BLOCK LETTERS)

1. (a) Name of the Principal CGHS Card Holder :
   (b) CGHS Ben ID No. :
   (c) Employee Code No. :
   (d) Ward Entitlement – Pvt./Semi-Pvt./General :
   (e) Full Address :

   (f) Mobile telephone No. and e-mail address, if any :

2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal CGHS card holder :

3. Name & address of the hospital / diagnostic center / Imaging center where treatment is taken or tests done:

4. Whether the hospital/diagnostic/imaging center is empanelled under CGHS : Yes/No

5. Treatment for which reimbursement claimed
   (a) OPD Treatment /Test & investigations :
   (b) Indoor Treatment :

6. Whether treatment was taken in emergency : Yes/No

7. Whether prior permission was taken for the treatment : Yes/No

8. Whether subscribing to any health/medical insurance scheme, If yes, amount claimed/received : Yes/No

9. Details of Medical Advance taken, if any :

10. **Total amount claimed**
    (a) OPD Treatment :
    (b) Indoor Treatment :
    (c) Tests/Investigation :

11. Name of the Bank : ..... SB A/c No.: .....
    Branch MICR Code: ..... IFSC 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 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.

Date :

( )

NATIONAL BOOK TRUST, INDIA VASANT KUNJ, NEW DELHI

Modified check list for reimbursement of medical claims

01	CGHS Token No. and place of issue (or Ben ID of Employee/Pensioner)	
02	Validity of CGHS Card	From.....to.....
03	Entitlement	Pvt. /Semi Pvt./General
04	Full name of Principal Card Holder	
05	Full name of patient & Relationship with the Principal Card Holder	
06	The following documents are submitted (Please tick (-/)I the relevant column)	
(a)	Medical 2004 Form (Revised)	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 Specialist/CMO	Yes/No
(f)	Whether the hospital has given break up for lab investigations	Yes/No
(g)	Original papers have been lost the following documents are submitted – I Photocopies of claim papers II Affidavit on Stamp Paper	 Yes/No Yes/No
(h)	In case of death of card holder the following documents are submitted: I Affidavit on Stamp paper by Claimant II No objection from other legal Heirs on stamp papers III Copy of death certificate	 Yes/No Yes/No Yes/No

Date : ....
Place: ....

Signature of Principal CGHS Card holder
Tel. No. (O)
(R)

Name of the Bank .....Branch.....SB Account No. .....
Branch MICR Code .....Tel. No. of Bank Branch .....

Proforma no.-1

UNDERTAKING

I..... .....(name , designation and contact no.) solemnly Affirm that my husband/wife Shri/Smt..... (name, designation and Contact no.) has been working in the office/ministry..... (name, address and landline no.)He/She has not preferred any medical claim from his/her department in respect of self or family or both.

I further undertake that he/she has not been paid medical allowance from his/her office.

The above information is given to the best of my knowledge and belief. I am aware that in case the information is found false at any stage, I can be prosecuted under CCS (CCA) Rules 1965 as amended from time to time

Date:

Signature

Name.....

Designation.....

Residential address.....

.....

.....

Contact No.....