

CENTRAL GOVERNMENT HEALTH SCHEME
MEDICAL REIMBURSEMENT CLAIM FORM
(To be filled up by the Principal Card holder in BLOCK LETIERS)

1. (a) Name of the Principal CGHS Card Holder & :
 Designation :
- (b) CGHS Ben ID No. :
- (c) Employee Code No. :
- (d) Ward Entitlement -Pvt./Semi-Pvt./General :
 Basic Pay (excluding Grade Pay) :
- (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 centre /
 imaging centre where treatment is taken or tests done:

4. Whether the hospital/diagnostic imaging centre :
 is empanelled under CGHS

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

6. Whether treatment was taken in emergency :

7. Whether prior permission was taken for the treatment:

8. Whether subscribing to any health/medical insurance
 scheme, If yes, amount claimed/received :

9. Details of Medical Advance taken, if any :

10. Total amount claimed
 (a) OPO 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:

Place:

Signature of the Principal CGHS card holder

Documents to be attached

- 1 Photo copy of the CGHS card of the employee 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 CGHS 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.
- 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 / 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 wilful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.*

Annexure –I

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper

I, son / wife / daughter of.....and resident of
.....have lost / misplaced the original paper or
the same are not traceable. I hereby give an undertaking that I have not received any payment
against the 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 the original bills in future, I shall return the same to competent authority.

Deponent

Verified by Notary Public

Annexure – II

Draft for Affidavit on Stamp Paper for claiming medical reimbursement
IN CASE OF DEATH of a CGHS Card Holder

I,.....husband / wife / son / daughter of Late..... and resident of, hereby submit the medical reimbursement 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 reimbursable amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp paper is enclosed.

Deponent

Attested by Notary Public

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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.....
(--).....
(--).....
(--).....

being the legal heirs of Late Shri/Smt.....have no objection if the entire amount reimbursable pertaining to the treatment of late Shri / Smtis paid to Shri / Smt

(i) (Signature)
Name:
Address:

(ii) (Signature)
Name
Address:

(iii) (Signature)
Name:
Address

(iv).....

(v).....

(vi).....

Verified by Notary Public