OFFICE OF THE PRINCIPAL CONTROLLER OF ACCOUNTS (FYS)
10- A, SHAHID KHUDIRAM BOSE ROAD, KOLKATA- 700 001

FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR TREATMENT OF CENTRAL GOVT. SERVANTS AND THEIR FAMILIES.

Authority : - Appendix VII Central Services (Medical Attendance)

N.B : - Separate Form should be issued for each patient.

1	Name and designation of Govt. servant (in block letters)	
2	Section in which employed	
3	Pay of the Govt. servant as defined in the Fundamental Rules and any other emoluments Which should be shown separately	
4	Place of duty	
5	Actual Residential Address	
6	Name of the patient and his/her relationship to the Govt. servant (in case of children state also)	
7	Place at which patient fell ill	
8	Detailed of amount claimed :	
	[a] Medical Attendance Fee for consultation indicating the name & designation of the Medical Officer consulted and the Hospital or Dispensary to which attached.	
	[b] The number & date of the consultations and the fee paid for each consultation.	
	[c] The number of injection and the fee paid for each injection.	
	[d] Whether the consultation were at the consulting room of Medical officer or at the residence of the patient.	
	[e] Charges for pathological or other similar test undertaken during the diagnosis.	
9	Cost of the Medicine Purchased	

10	Total amount claimed	
11	List of enclosures	

TO BE SIGNED BY THE GOVERNMENT SERVENT

1. I hereby declare that the statements in this application are true to the best of my knowledge and belief and the person for whim medical expenses were incurred is wholly depended upon me.

2. It is certified that no. Govt. Fair shops/co-operative/consumer stores/drug store or run by the Central or State Govt. of local bodies or any other organization recognized under the co-operative societies act existing within radius of 2 kilometers from a place of residence and I am not residing in the area covered by CGHS.

3. It is certified that my patient/father/mother/son/daughter/wife is wholly depended upon me and resides with me. His/Her income from all sources including pension before commutation does not exceed Rs. 3500/-. I have no earning brothers.

4. I certified that my wife is not a Govt. servant nor she has any other source of income.

Date:

[Signature of the Govt. Servant]

Office to which attached _____

_____ Section _____

_____ A/c No. _____

Certified that the claim has been scrutinized with reference to the relevant orders and instructions issued from time to time and the claim appears to be genuine.

No. _____ Dt._____

Counter Signed.

Accounts Officer[Fys]
Received Payment
Rs. _____

Rupees _____ for payment by including in the establishment pay bill

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

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

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ESSENTIAL CERTIFICATE – 'A'

Certificate granted to Mr./Mrs./Miss/Kumari _____ father/mother/son/wife/daughter of Mr. /Mrs./Miss/ Kurari _____ employed in the Office of the Principal Controller of Accounts[Fys] :-

CERTIFICATE – 'A'

a) I, Dr. _____ hereby Certified that I charged and received Rs. _____ for consultation on _____ at my consulting room/at the residence of the patient.

b) That I charged and received Rs. _____ for administering intra-camous/intra muscular/sub-cutaneous injections on _____ at my consulting room/at the residence of the patient.

c) That the injection administered were/were not for imunising or prophylactic purposes.

d) That the patient has been under treatment at _____ hospital/my consulting room and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the ---------- ------ for supply to private patient and do not include proprietary preparations for which cheaper substitute of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfections.

	Name of Medicines [in block letter]	**Amount** [Rs.]		**Name of Medicines** [in block letter]	**Amount** [Rs.]
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		
TOTAL			**TOTAL**		

e) That the patient is/was suffering from _____ and is/was under my treatment from _____ to _____.

f) That the patient is/was not given prenatal or post natal treatment.

g) That X-ray, Laboratory test etc. for which an expenditure of Rs. _____ was incurred was necessary and were undertaken on my advice at _____.

h) That I referred that patient to Dr. _____ for specialist consultation and the necessary approval of the Director of Health Services, West Bengal as required under the rules was obtained.

i) That the patient did not requires/required hospitalization.

Date: _____

_____

[Signature and designation of the medical officer & the Hospital/ Dispensary to which attached]

Registration No. _____

N.B.

Certificate not applicable would be struck off.
Certificate is compulsory and must be filled in by the Medical Officer.

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 : .....

Place: ..... **Signature of the Principal CGHS card holder**