CENTRAL COUNCIL FOR RESEARCH IN AYURVEDIC SCIENCES

J.L.N. Bharatiya Chikitsa Evam Homoeopathy Anusandhan Bhawan
61-65, Institutional Area, Opp. 'D' Block, Janakpuri,
New Delhi-110058

F.No.______________________ Date______________

MEDICAL CHARGES REIMBURSEMENT BILL

Bill No.______________

District_
Voucher No.
for Rs.__ ______

Detailed medical bill of the establishment of the ______________________
______________________ for the month of_ ___

HEAD OF ACCOUNTS

Major head______________
Minor head______________
Detailed head______________

Grant No./Appropriation______________
Group head______________
Sub-head or Unit______________

Sl.No.	Section of Estt.& Name of incumbent	Gross claim	Recovery of Adv.	Net amount payable	Remarks
1.	2.	3.	4.	5.	6.

DETAILS OF MEDICAL CHARGES REFUNDED

Section of Establishment & Name of Incumbent	Period	Amount Rs.	ps.

Signature of the Drawing Officer

Designation_______________

Passed for_______________

Rupees_______________

____

Certified that the claim has been examined and found genuine.

Signature of the Officer Incharge.

Certified that the AMA consulted by the claiment has been authorised by the State/ Central Govt./CGWCC. of the State.

Signature of the Officer Incharge.

NOTE : The bill should be supported by the essentially certificates receipts, prescription slips of Doctor, payment vouchers and certificates etc.

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CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. and Place of Issue :
2. Validity of CGH Card : From ________ To ________
   (For pensioners and Entitlement   Pvt./Semi Pvt./General
3. Full Name of Card Holder :
   (Block Letters)
4. Status(Government Servant/
   Pensioner/Other)
5. The following documents are :
   submitted(Please tick( ) the
   relevant column)
   (a) Medical 2004 Form : Yes/No
   (b) Photocopy of CGHS card : Yes/No
   (c) Essentiality Certificate : Yes/No
   (d) No of Original Bills : ________
   (e) Whether original bills/
       Vouchers have been verified : Yes/No
   (f) Copy of discharge summary : Yes/No
   (g) Copy of Permission letter : Yes/No
   (h) Whether the hospital has :
       given break-up for Lab. : Yes/No
       investigations
   (i) Original papers have been
       lost the following documents
       are submitted________
       1. Photocopies of claim :
          Papers Yes/No
       II. Affidavit on Stamp Paper : Yes/No
   (j) In case of death of card
       holder, the following
       documents are submitted____
       I. Affidavit on Stamp paper :
          by Claimant Yes/No
       II. No objection from other
          legal heirs on Stamp
          papers : Yes/No
       III. Copy of death certificate : Yes/No

Dated__________

Signature of CGHS Card holder
Tel.No.(O)
(R)
e-mail Address

Name of the Bank__________ Branch____________ SB A/c No.______

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FORM FOR REIMBURSEMENT OF MEDICAL
CLAIMS OF CGHS BENEFICIARIES

MEDICAL 2004

(To be filled by the claimant

1. CGHS Token No.and Place of issue :
2. Validity of CGHS Token Card and entitlement : From ________ to ________ Pvt/Semi Pvt./General
3. Full name of the Card holder (Block letters) :
4. Full Address
5. Telephone No. (O)________ (R)________
6. E-mail address if,any :
7. Name of the Bank ________ Branch ________ SB A/c No.________
8. Name of the patient and relationship with the card holder :
9. Status tick( ) (Government Servant/Pensioner/Serving employee or pensioner of autonomous body/Member of Parliament/Ex.M.P./Ex. Governor/Former judge of Supreme Court/Former Judge of High Court/ Freedom Fighter/Legal Heir/Others)
10. Basic Pay/Basic Pension :
11. Name of the Hospital with Address :
    (a) OPD treatment and investigations :
    (b) Indoor Treatment :
12. Date of Admission ________ Date of Discharge ________
    (In case of Indoor Treatment Only)
13. Total amount Claimed :
    (a) OPD Treatment :
    (b) Indoor Treatment :
14. Details of Permission :
15. Details of Medical advance if,any :

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.

Dated:

Signature of CGHS card holder

Contd....2/-

Essentiality Certificate-cum-statement of expenditure certified by treating specialist(to be submitted in duplicate)

(Strike out whichever is not applicable)

1. Name of the patient and relationship with card holder :
2. Details of expenditure :

(A) OPD Treatment Diagnosis

(I) Name of the Hospital :

(ii) Total No. of vouchers :

(III) Amount claimed :

(Indicate serial number of individual vouchers with name and address of the shops with date against each sub-heading in a separate annexure wherever required)

	Amount claimed	Amount admissible (for official use)
(a) Medicine	________	________
(b) Consulation fees (specify number of consultations)	________	________
(c) Laboratory Charges (Break-up in a separate annexure)	________	________
(d) Disposable Surgi-sundries	________	________
(e) Special devices like hearing aid/artificial appliances,etc.(Specify)	________	________
Total	________	________

Contd.....3/-

(B) Indoor Treatment **Diagnosis** ______________

(To be marked N.A. wherever necessary)

(Details of Hospital Bill and other vouchers pertaining to the period of indoor treatment)

(a) Name of the Hospital with address :

(b) Period of Bill: From______________ To ______________

(c) Amount claimed

(Indicate Serial No. of individual vouchers with name and address of shops with date against each sub-heading in a separate annexu wherever required)

	Amount claimed	Amount admissible (for official use)
(i) Room Rent: ICU/ICCU/Ward From________ To________	______________	______________
(ii) Charges for:		
(a) O.T.	______________	______________
(b) O.T. Consumables	______________	______________
(c) Anaesthesia	______________	______________
(d) Procedure	______________	______________
(iii) Medicines	______________	______________
(iv) Implants like pacemaker joint replacement Coronary stent, etc. (details)	______________	______________
(v) Artificial devices (details)	______________	______________
(vi) Lab. charges (Break-up given in Annexure)	______________	______________

contd---4/-

any

(viii)Miscellaneous ____________ ____________

Total ____________ ____________

Signature of Claimant

Name in Block Letters____________

Address and ____________

Telephone No. ____________

____

1. Certified that the relevant bills/vouchers have been verified by me and the expenditure shown above is correct and the treatment services provided are essential and minimum that is required for the recovery of the patient.

2. Certified that the services of special Nurse/Ayah were required from__________ to __________ that were absolutely essential for the recovery of the patient.

3. Specific procedure/Operation performed was____________

Signature of the Treating
Specialist with official seal

Countersigned by Medical Superintendent
of the Hospital with seal
(For Indoor treatment only)

DEPENDANCY CERTIFICATE

I_________________________________declare that my mother/father Age________________years is entirely dependant upon me and is permanently residing with me with effect from__________________. I further declare that my mother/father is not an earning member and his/her total monthly income from all sources including income from land holding/rent on building etc. is Rs.____________________/Nil.

Signature of employee_______

Name________________________

Designation_________________

Address_____________________

Countersignature of Officer-in-Charge/Project Officer SEAL OF Unit/Institute.

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NON EMPLOYMENT CERTIFICATE

This is to certify that Smt.____________ wife of Shri____________________is not employed in any Private Organisation State or Central Govt. Organisation.

Signature______________

Designation____________

Address________________

Dated__________________

Counter signature of Officer Incharge/
Project Officer Seal of Unit/Institute.