CENTRAL GOVERNMENT HEALTH SCHEME
CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. and Place of Issue : _____
   _____
2. Validity of CGHS Card (For pensioners) & Entitlement of Ward : From _____ to _____ Pvt. / Semi Pvt. / General
3. Full Name of Card Holder (in Block Letters): _____
4. Status (Govt 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 breakup for Lab Investigations	Yes / No
(i)	If the original papers have been lost the following doct. are submitted -	
	I. 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 [_____]
Designation : _____

Tel. No. (O) _____
(R) _____
Branch / Address _____
_____

Please furnish Name of the Bank _____ Branch _____ and SB A/C No. _____ where payment has to be deposited.

CENTRAL GOVERNMENT HEALTH SCHEME
MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF CGHS BENEFICIARIES.

Computer No.

(To be filled by the claimant)

1. CGHS Token No. and Place of Issue : _____
   _____
2. Validity of CGHS Card (For pensioners) & Entitlement of Ward : From _____ to _____ Pvt. / Semi Pvt. / General
3. Full Name of Card Holder (in Block Letters) : _____
4. Full Address of Communication : _____
   _____
   _____
5. Telephone No. : (O) _____ (R) _____
6. Designation : _____
7. Name of the Bank, Branch & SB A/c No. : _____
   _____
   _____
8. Name of the Patient & Relationship with the card holder _____
   _____
9. Status (Govt Servant / Pensioner / Other) _____
10. Basic Pay / Basic Pension : Rs. _____
11. Name of the Hospital with Address: _____
    _____
    (a) OPD Treatment and Investigations. _____
    (b) Indoor Treatment. _____
    I. Date of Admission _____
    II. Date of Discharge _____
12. Total amount Claimed Rs. 0.00
    (a) OPD Treatment Rs. 0.00
    (b) Indoor Treatment Rs. _____
13. Details of Permission : _____
14. Details of Medical advance (if any) : Rs. _____

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 dependant 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*

ESSENTIALITY CERTLFICATE-CUM-STATEMENT OF EXPENDITURE CERTIFIED BY TREATING SPECIALIST

(to be submitted in duplicate).

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 : Rs. 0.00

(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).

(a) Medicine Rs. 0.00

Sl. No.	Name of Medicine(s)	Name of Chemist (M/s.)	Cash Memo No. & Date	Price Rs.	P.
1.					
2.					
3.					
4.					
5.					
6.					

(b) Number of Consultations Taken (with date) & _____
Total Consultation Fees Paid Rs. _____

(c) Laboratory Charges Rs. 0.00

Sl. No.	Name of Laboratory / Radiology Investigation	Name of Laboratory (M/s.)	Cash Memo No. & Date	Price Rs.	P.
1.					
2.					
3.					
4.					
5.					
6.					

(d) Cost of Disposable Surgicals / Sundries. Rs. _____

(e) Cost of Special devices like hearing aid / artificial appliances etc. (Specify). Rs. _____

(f) Miscellaneous Charges (Specify). Rs. _____

TOTAL : **Rs.** 0.00

Admissible for Rs. _____ only *(for Office use only)*

Contd..2

(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 : Rs. _____

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

(i) Type of Ward Occupied : _____

(ii) Duration of Stay : From _____ To _____

(iii) Rent Paid : Rs. _____

(iv) Charges Paid for :

(a) O.T. : Rs. _____

(b) O.T. Consumables : Rs. _____

(c) Anaesthesia : Rs. _____

(d) Procedure : Rs. _____

(v) Medicines : Rs. _____

Sl. No.	Name of Medicine(s)	Name of Chemist (M/s.)	Cash Memo No. & Date	Price Rs.	P.
1.					
2.					
3.					
4.					
5.					
6.					

(vi) Charges of Implants i.e. Pacemaker, Joint Replacement, Coronary Stent etc. (details) : Rs. _____

_____

(vii) Artificial Devices (details) : Rs. _____

(viii) Laboratory Charges : Rs. _____

Sl. No.	Name of Laboratory / Radiology Investigation	Name of Laboratory (M/s.)	Cash Memo No. & Date	Price Rs.	P.
1.					
2.					
3.					
4.					
5.					
6.					

Contd...3

(ix) Special Nurse / Aya (if any) Rs. _____

(x) Miscellaneous Rs. _____

TOTAL **Rs. _____**

Admissible for Rs. _____ only *(for Office use only)*

Signature of Claimant [_____]

Name in Block Letters : _____

Designation : _____

Branch / Address :_____

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 required for the recovery of the patient.
2. Certified that the services of Special Nurse/Aya 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.)