**ICMR-National Institute for Implementation Research on Non-Communicable Diseases, Jodhpur**

**(For serving employees)**

**MEDICAL REIMBURSEMENT CLAIM FORM**

* + - 1. Name of the Principal CGHS Beneficiary Card Holder :
      2. Unique ID No. :
      3. Employee Code No. :
      4. Ward Entitlement-Pvt/Semi-pvt/General :
      5. Full Address :
      6. Mobile No. & Email address, if any :
      7. Patient’s Name :
      8. Patient’s CGHS Beneficiary Unique id No. :
      9. Relationship with the Principal CGHS Ben Card Holder:

1. Name & address of the hospital/diagnostic center/

imaging center where treatment is taken or tests done :

1. Whether the hospital/diagnostic/imaging center is

empanelled under CGHS :

1. Treatment for which reimbursement claimed
   * + 1. OPD treatment/Test & investigations :
       2. Indoor treatment :
2. Whether treatment was taken in emergency :
3. Whether prior permission was taken for the treatment :
4. Whether subscribing to any health/medical insurance :

scheme, if yes, amount claimed/received

1. Details of Medical Advance taken, if any :
2. Total amount claimed :
3. OPD Treatment :
4. Indoor Treatment :
5. Tests/Investigation :
6. Medicines :

**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 in wholly dependent on me. I am a CGHS beneficiary and the CGHS beneficiary 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 beneficiary card holder**

**ESSENTIALITY CERTIFICATE**

(To be completed in the case of patient who are not admitted to the hospital for treatment)

Certificate granted to Wife of employeed in the office of ICMR-National Institute for Implementation Research on Non-Communicable Diseases, Jodhpur.

I, Dr………………………………………….hereby certify:-

1. that I charged and received Rs **135/-** for…………………….Consultation on at my consulting room after Dispensary hours.
2. that I charged and received Rs……………for administrating …………….intra-muscular/ intra-venous injection on………………at………………………my consulting room after Dispensary hours.
3. that the injection administered was/were not for immunizing or prophylactic purpose.
4. that the patient has been under my treatment at my consulting room and that the mentioned medicines prescribed by me in this connection were essential for the recovery of serious deterioration in the condition of the patient. The medicines are not in stock in the …………………………………………..hospital/Dispensary for supply to private patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparations which are primarily foods, toilets and disinfectants.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S No** | **Bill No.** | **Bill Date** | **Name of Medicine/Lab Test** | **Amount**  **(In Rs.)** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |

1. that the patient is/was suffering from……………………………………and is/was under my treatment from…………………….to……………………..
2. that the X-ray, laboratory tests etc. dated ………………….for which an expenditure of Rs……………………..was incurred was necessary and were undertaken on my advice at the…………………………
3. that the patient did not require hospitalization.
4. that I referred the patient to Dr…………………….for special consultation and the necessary approval of the ………………….as required under the rules was obtained vide his letter memo no………………dated……………………
5. that the case was definitely not of prolonged treatment.
6. that the hospital/dispensary to which I am attached is recognized for treatment of Central Government Employees.
7. that I was not on privilege leave during this period of treatment.
8. that the treatment is over/continuing.

**Signature of Medical Officer/Hospital Superintendent**