EMPLOYEE HEALTH SCHEME
MEDICAL REIMBURSEMENT CLAIM FORM

(To be (filled up by the EHS Card holder in **BLOCK LETTERS**)

1. (a) Name of the EHS card Holder-
   (b) EHS Card Number –
   (c) Employee Code Number-
   (d) Ward Entitlement – Pvt./Semi-Pvt./General –
   (e) Full Address-

   (f) Mobile telephone number and e-mail-

2. (a) Patient 'name-
   (b) Patient's EHS Number –
   (c) Relationship with the EHS Card holder-

3. Name & address of the hospital/diagnostic center/
   Imaging center where treatment

4. Whether the hospital/diagnostic/ imaging center is
   Empaneled under EHS. 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) Test/Investigation-

11. Name of the Bank ……SB A/C Number…….....
    Branch MICR Code:……IFSC Code…….

Declaration

I hereby deciare 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 EHS beneficiary and the EHS card was valid at the time of treatment. My monthly EHS contribution is deducting from my salary .I agree for the reimbursement as is admissible under the rules.

Date……

Place……. Signature of the EHS Card Holder

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 and the exact number of tests, X-ray films, etc.) as the reimbursement amount is calculated as per approved CGHS/AIIMS Rates per test.
B. In case of loss of original papers, Affidavits as per Annexure I to be submitted. AH 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/ 1CD etc. copy of the warranty certificate of earlier pacemaker/ICD may be enclosed.

Annexure-I

Draft for Affidavit for duplicate Claim papers bills on stamp paper

.....son/wife/daughter of ……..and resident of ……have lost 1 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 paper 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.

Signature

Verified by Notary public

Annexure- II

Draft for Affidavit on Stamp Paper for claim medical reimbursement
IN CASE DEATH OF A EHS CARD HOLDER

I……..Husband/Wife/Son/Daughter of late and resident of …….hereby submit the medical reimbursement claim 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 reimbursement amount is paid to me.

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

Deponent.

Attested by Notary Public.

Draft for No Objection Certificate to Stamp paper-

(I) We_____S/O,_____D/O_____
late Shri_____

(II) S/o_____ D/o _____
Late Shri _____

(III) _____

(IV) _____

Being the legal heir of Late Shri/Smt_____have no objection if the entire amount reimbursable pertaining to the treatment of late Shri/ Smt _____is paid to Shri/Smt_____

(i) Signature-	(II) Signature-	(III) Signature-
Name-	Name-	Name-
Address-	Address-	Address-

Verified by Notary Public