

REIMBURSEMENT CLAIM FORM

1. Name of the Railway/Retd. Employee (in BLOCK letters)
2. Designation of the Railway/Retd. Employee (in BLOCK letters)
3. Office and Station of employment
4. Pay/Last Pay of the Railway/Retd. Employee including garde pay
5. Residential address
6. MIC/RELHS no. and issuing Authority
7. MIC/RELHS registered at H Unit/Hospital

I (A) Name and age of the patient

II (B) Patient's relationship to the Rly/Retd. Employee

III Details of Indoor/OPD Treatment at Non-Railway Institute

- A. Name of Hospital:
- B. Date of Admission:
- C. Date of Discharge:
- D. Diagnosis:
- E. Amount of Total Hospital Bill (Attach detailed bill):
- F. Whether Treatment was taken in Emergency:
- G. Are you a CTSE member (Y/N)

IV. Whether subscribing to any Health Insurance Policy¹ or covered under any other health scheme:

If yes, have you received any amount from insurance company for the treatment in question. Give details if any on separate sheet of paper.

V. Total Amount Claimed:

VI: Details of Bank account where Reimbursement amount is to be paid:

- | | |
|---------------------|----------------|
| a. Name of the Bank | b. Account No. |
| c. Branch MICR Code | d. IFSC Code |

VII. List of enclosures (Please Tick the documents attached and write additional documents)

- A. Photocopy of MIC/RELHS card
- B. Essentiality cum Emergency Certificate by the Non Rly Hospital
- C. Discharge Summary
- D. Original Bills of Hospital
- E. Original Cash vouchers of Drugs/consumables/implants etc. if relevant
- F. Outer pouch of Stent, pacemaker, Implants etc.
- G. Any other enclosure

(In case of many enclosures, write number of additional enclosures here and attach a separate sheet with

details)

DECLARATION TO BE SIGNED BY THE RAILWAY EMPLOYEE

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me. I am aware that misuse of medical facilities or misrepresentation of any kind can attract penal action including cancellation of MIC/RELHS Card. I hereby declare that this is my final claim and I shall not make any claim in future to Rly or any other health scheme in respect to this treatment episode.

Date

Place

Signature of the Railway employee

¹ In case the beneficiary has medical insurance policy and intend to make claim for the treatment in question then he/she may make claim to insurance company first and then submit claim to Rly with documents, bills etc. attested by insurance company.

..... RAILWAY

MEDICAL DEPARTMENT

ESSENTIALITY cum EMERGENCY CERTIFICATE

I certify that Shri/Shrimati/Kumar/Kumari wife / son /
daughter / dependent relative of Shri / Shrimati ,
employed in Indian Railway as , has been under my treatment for
..... disease from to
at the hospital and that the treatment as described in the attached
Discharge Card No., and attached bills thereon were provided due to an emergency
situation, treatment for which could not have been delayed. I further certify that the treatment provided was
essentially required.

.....
Signature of the Medical Officer
In charge of the case at the non-Railway hospital.
with Name and Stamp/Seal

Signature of Hospital In-charge or
Authorized signatory with Stamp/Seal

amp

EAST COAST RAILWAY

CHECK LIST OF MEDICAL REIMBURSEMENT CLAIM

A – CHECK LIST FOR THE APPLICANT:-

- | | |
|--|-----------|
| 1. Claimant has given application to CMS/MD explaining the circumstances under which treatment taken in a non-Railway hospital, alongwith his/her postal address and telephone number. | Yes/No/NA |
| 2. The claim has been submitted by filling the Reimbursement claim form completed in all aspects, The amount claimed has been rightly mentioned in the appropriate columns, the forms have been signed by the claimant, treating doctor, Hospital in-charge/ authorized signatory. | Yes/No/NA |
| 3- The claim is forwarded through the department with signature & stamp of controlling officer. | Yes/No/NA |
| 4. Referral letter of AMO is enclosed in the claim, if the case has been referred by AMO. | Yes/No/NA |
| 5. Discharge summary of the treating hospital in original is enclosed signed by treating doctor | Yes/No/NA |
| 6. Original Medicine-bills, Original Investigation reports submitted, signed by treating Doctor | Yes/No/NA |
| 7. Summarized Hospital Bill in original with breakup of expenditure, signed by treating Doctor | Yes/No/NA |
| 8. Cash memo/Invoice in support of claims for purchase of Stent, IOL, Pacemaker, Hearing Aid, Prosthesis, etc along with original Sticker, CD (if any) signed by treating doctor on each. | Yes/No/NA |
| 9. The party has submitted the details of the medicines purchased in a separate list as annexure. | Yes/No/NA |
| 10. (a) Latest Declaration Form duly signed & copy of Medical Card(self attested) from the Railway employee/Copy of RELHS card(self attested) in case of RELHS card holder | Yes/No/NA |
| (b) Self declaration for dependent relative towards ceiling limit of income as per standard format (if the patient is a dependant relative) | Yes/No/NA |
| (c) Self declaration for claiming medical reimbursement of son above 21 years, who is not a student or invalid, as per standard format. | Yes/No/NA |
| 11. Declaration about non-claiming of reimbursement claim from Insurance Company/ other sources as per standard format. | Yes/No/NA |
| 12. All the pages are serially numbered and total number of pages is mentioned in the application. | Yes/No/NA |
| 13. The claim is submitted in duplicate, one original & one photocopy. | Yes/No/NA |
| 14. List of enclosers mentioned in a separate sheet. | Yes/No/NA |
| 15. Bank details with ECS mandate form duly filled in and signed is submitted | Yes/No/NA |
| 16. In case of submission of claim beyond 6 months, condone certificate from Finance is enclosed. | Yes/No/NA |

B –CHECK LIST FOR RLY. HOSPITAL SENDING THE CLAIM FOR SANCTION (In addition to above Check list):

- | | |
|---|-----------|
| 17. Emergency ex-post-facto has been certified by MD/CMS | Yes/No/NA |
| 18.- Scrutinization summary sheet enclosed mentioning admissible, disallowed amount | Yes/No/NA |
| 19. CMS/MD has recommended the admissible amount for sanction | Yes/No/NA |
| 20. Concurrence of Associate finance & DRM's approval obtained | Yes/No/NA |

*Strike out whichever is not applicable.

Signature of the Recommending Authority

**DECLARATION ABOUT DEPENDENT RELATIVES BY THE RAILWAY EMPLOYEE/RELHS
CARD HOLDER FOR AVAILING MEDICAL FACILITIES**

I, _____ (Name of the Railway Employee/ RELHS
Card Holder), Design. _____, Dept. _____,
Station. _____, having Medical Card/RELHS Card No. _____
hereby declare that Shri/Smt/Kum _____ (Name of the
dependent relative), Age _____ years, related to me as my _____
(relation), whose name has been included as my dependant relative as per Pass Rules, is having
monthly income or ₹..... for all sources and is entitled for grant of free medical facilities as
dependant relative as per Rly.Bd's Lr. No.2010/H-1/2/21 dtd.21.04.2017.

If the declaration given by me is subsequently found to be false, action as deemed fit, may be
taken against me.

Date:

Signature of Railway Employee/RELHS Card Holder

Design. :-

Address:-

**DECLARATION ABOUT DEPENDENT SON, MORE THAN 21 YEARS OF AGE, NOT A
STUDENT OR INVALID, BY THE RAILWAY EMPLOYEE/RELHS CARD HOLDER FOR
AVAILING MEDICAL FACILITIES**

I, _____ (Name of the Railway Employee/ RELHS

Card Holder), Design. _____, Dept. _____,

Stn. _____, having Medical Card/RELHS Card No. _____

hereby declare that Shri _____ (Name of the dependent son),

Age _____ years, who is not a student or invalid, is entitled to get free medical facilities as:-

- a- He is unmarried
- b- He does not have any source of income
- c- He is wholly dependent on me
- d- He is residing with me

If the above declaration given by me is subsequently found to be false, action as deemed fit
may be taken against me.

Date:

Signature of Railway Employee/RELHS Card Holder

Design. :-

Address:-

To

The CMS/MD.....

Sub: Declaration regarding non-claiming of the reimbursement from insurance company/ other sources.

Ref: Railway Board's Lr.No.2009/H/6-4/Policy dtd.09.04.2015

I, Shri/Smt..... hereby declare that
I have not claimed any amount as reimbursement towards treatment expenditure of this
reimbursement claim for treatment of self/dependant relative
..... (Name & relation) from any other
source including insurance company. The period of treatment is (from..... to
.....) at Hospital.

Date:

Signature of applicant:

Name :

Designation:

Department:

Station:

Mobile No.