

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 Policy 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

