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CENTRAL GOVERNMENT HEALTH SCHEME
CHECKLIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. CGHS Token No. and place of issue' :
2. Validity of CGH Card (For pensioners)& Entitlement : from .....to.....
   : Pvt. / Semi Pvt./General
3. Full name of Card Holder (Block Letters) :
4. Status (Govt Servant/Pensioner/Other)
5. The foHowing documents are submitted (Please tick (-/) the relevant column) :

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(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)	Original papers have been lost the Following documents are submitted	
	I. Photocopies of claim papers	: Yes/No
	II. Affidavit on Stamp Paper	: Yes/No.
(j)	Incase 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

Tel. No. (0)
(R)
e-mail Address

Name of the Bank .... Branch..... ..... SB.A/C No.

CENTRAL GOVERNMENT HEALTH SCHEME
MEDICAL 2004 FORM FOR REIMBUREMENT OF MEDICAL CLAIMS OF CGHS BENEE\FICIARIES.
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Computer No.

(To be filled by the claimant)

1. CGHS Token No. and Place of issue :
2. Validity of CGHS Token Card : from.....to.....
   & entitlement : Pvt. / Semi Pvt. / General
3. Full name of the card holder (Block Letters) :
4. Full address :

5. Telephone no. (O).....(R).....
6. E-mail address if, any:
7. Name of the Bank .....Branch.....SB A/C.
5. Name of the patient & relationship with the card holder :
6. Status tick (√) (Govt. Servant/Pensioner/Serving employee or pensioner of autonomous body / Member of Parliament/Ex-M.P./Ex-Governor/Former Judge of Supreme Court/Former Judge of High Court/Freedom Fighter/Legal Heir/others)
7. Basic Pay/ Basic Pension
8. Name of the Hospital with Address:
   (a) OPD treatment and investigations.

   (b) Indoor Treatment.

9. Date of admission.....Date of discharge.....(In case of Indoor Treatment only)
10. Total amount Claimed
    (a) OPD Treatment.
    (b) Indoor Treatment.

11. Details of Permission :
12. Details of Medical advance if, any:

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.

Date: Signature of CGHS card holder

Essentiality Certificate-cum-statement of expenditure certified by treating specialist (to be submitted In duplicate).

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Strike out whichever is not applicable

1. Name of the patient and relationship with Card Holder :

2. Details of Expenditure :

(A) OPD Treatment **Diagnosis**

(I) Name of tile Hospital :
(II) Total No. of vouchers :
(lll) Amount claimed :

(Indicate serial number of individual vouchers With name and address of the shops with date against each sub heading in a separate annexure whenever required).

	Amount Claimed	Amount Admissible (for official use.)
(a) Medicine	----------	----------
(b) Consultation fees (specify number of consultations.	----------	----------
(c) Laboratory Charges (Break-up In a sepe-rate annexure,)	----------	----------
(d) Disposable Surgi Sundries.	----------	----------
(e) Special devices like hearing aid/ artificial appliances etc. (Specify).	----------	----------
(f) Miscellaneous (Specify)	----------	----------
Total.	----------	----------

(P.T.O.)

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

		Amount claimed	Amount admissible (for office use)
(i)	Room Rent ICU / ICCU / Ward From_____to_____	_____	_____
(ii)	Charges for:	_____	_____
(a)	O.T	_____	_____
(b)	O.T. Consumables	_____	_____
(c)	Anastasias	_____	_____
(d)	Procedure	_____	_____
(iii)	Medicines	_____	_____
(iv)	Implants like pacemaker Joint replacement Coronary stent etc, (details)	_____	_____
(v)	Artificial devices (details)	_____	_____
(vi)	Lab Charges (Break-up given in Annexure)	_____	_____
(vii)	Spl. Nurse/Aya if any	_____	_____
(viii)	Miscellaneous	_____	_____
	Total	_____	_____

Signature of Claimant
Name in Block Letters
Address & Telephone No. if any.

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 the of 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).