***FORM – MRC (S)***

*(For serving employees)*

**CENTRAL GOVERNMENT HEALTH SCHEME**

**MEDICAL REIMBURSEMENT CLAIM FORM**

(To be filled up by the Principal Card Holder in BLOCK LETTERS)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | (a) | Name of the Principal CGHS Card Holder | **:** |  |
| (b) | CGHS Beneficiary ID No. | **:** |  |
| (c) | Employee Code No. | **:** |  |
| (d) | Ward Entitlement – Private / Semi-Private / General | **:** |  |
| (e) | Full Address | **:** |  |
| (f) | Mobile Telephone No. and e-mail address, if any. | **:** |  |
| 2 | (a) | Patient’s Name | **:** |  |
| (b) | Patient’s CGHS Beneficiary ID No. | **:** |  |
| (c) | Relationship with the Principal CGHS Card Holder | **:** |  |
| 3 | Name & Address of the Hospital / Diagnostic Center / Imaging Center where treatment is taken or tests done. | | **:** |  |
| 4 | Whether the Hospital / Diagnostic / Imaging Center is empanelled under CGHS | | **:** | Yes / No |
| 5 | **Treatment for which reimbursement claimed:** | | **:** |  |
| (a) | OPD Treatment / Test and 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) | Tests / Investigations | **:** |  |
| 11 | Name of the Bank | | **:** |  |
| S.B. Account No. | | **:** |  |
| Branch MICR Code | | **:** |  |
| IFSC Code | | **:** |  |

**D E C L A R A T I O N**

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 dependent on me. I am a CGHS beneficiary and the CGHC 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 Card Holder) |

Documents to be attached

1. Photocopy of the CGHS Card of the employee along with the patients CGHS Card.

2. Copy of permission letter, if any.

3. Emergency Certificate (Original), in case of emergency.

4. Copy of the Discharge Summary.

5. Ambulance Certificate (Original), if any.

6. Original Bills / Cash Memo / Vouchers, etc. for the reimbursement amount claimed.

**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, X-ray films, etc.) as the reimbursable amount is calculated as per approved CGHS rates per test.

b) In case of loss of original papers, **Affidavit** as per **Annexure-I** to be submitted. All 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 replacement of Pacemaker / ICD, etc., copy of the Warranty Certificate of earlier Pacemaker / ICD may be enclosed.

***Note:*** *Misuse of CGHS facilities is a criminal offence. Penal action, including cancellation of CGHS Card may be taken in case of wilful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.*

ANNEXURE - I

**Draft for Affidavit for Duplicate Claim Papers / Bills on Stamp Paper**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / wife / daughter of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and resident of have lost / misplaced the original paper or the same are not traceable. I hereby given an undertaking that I have not received any payment against the original bills / claim papers 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.

Deponent

Verified by Notary Public.

ANNEXURE - II

**Draft for Affidavit on Stamp Paper for claiming medical reimbursement**

**In case of Death of a CGHS Card Holder.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ husband / wife / son / daughter of late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and resident of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby submit the medical reimbursement claim papers 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 reimbursable 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”** on Stamp Paper.

We (i) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / daughter of Late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ii) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / daughter of Late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(iii) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / daughter of Late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(iv) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / daughter of Late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(v) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / daughter of Late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(vi) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son / daughter of Late \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

being the legal heirs 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  Name :  Address. | (ii) Signature  Name :  Address. | (iii) Signature  Name :  Address. |

|  |  |  |
| --- | --- | --- |
| (iv) Signature  Name :  Address. | (v) Signature  Name :  Address. | (vi) Signature  Name :  Address. |

Verified by Notary Public.