**REIMBURSEMENT CLAIM FORM**

**(ANNEXURE (A) TO LETTER NO. 494- E/Q VII DT. 24.2.99 amended vide Railway Board's letter No.2005/H/6-4/ Policy-I, Dated 01.06.2017)**

1. Name of the Railway/ Retired Employee (in BLOCK letters): ……..……

2. Designation of the Railway/ Retired Employee (in BLOCK letters) : ……..……

3. Office and Station of Employment: …….

4. Pay/Last Pay of the Railway/ Retired Employee including grade pay: ……..

5. Residential address: …….

……..…….....Phone No. ….....

6. Medical I. Card /RELHS No. : …… and Issuing Authority: …….....
7. I. Medical I. Card /RELHS registered at Health Unit/ Hospital. : ……

II. (A) Name and age of the Patient : ……Age : …….Years

II. (B) Patient's relationship to the RLy./Retd. Employee: ……

III. Details of Indoor 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 CSTE 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 Bank: ……. b. Account No. : ……

c. Branch MICR Code: …… d. IFSC Code: ……

contd. 2 page

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

A. Photocopy of Medical I/Card/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 for 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 Railway or any Health scheme in respect to this treatment episode.

…….
Signature of Railway employee/ Claimant

Date ……

Place ……..

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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 Railway with documents, bills etc. attested by insurance company.

Check List

| S.N. | Particulars | Placed at S.N. |
|---|---|---|
| 1 | Photo Copy of Medical Identity Card/ RELHS Card duly attested | |
| 2 | Essentiality-cum-Emergency Certificate (Signed by the Medical Officer in-charge of the case at the non-Railway Hospital with Name and Stamp/Seal) | |
| 3 | Discharge Summary/ Death Summary | |
| 4 | Original Bills of Hospital (Duly verified & countersigned by treating Doctor (Authorized Medical Officer). Not by Casualty Doctor) | |
| 5 | Original Cash Vouchers of Drugs/Consumables, Implants etc. if relevant. | |
| 6 | Outer Pouch of Stent, Pacemaker, Implants etc. | |
| 7 | Any other enclosure---------- ( in case of many enclosures, write number of additional enclosures here and attach a separate sheet with details) | |
| | a-Attested Copy of Pay Slip/ PPO Pension Order | |
| | b-Attested Copy of PAN Card | |
| | c-ECS/RTGS MANDATE FORM with Cancelled Cheque | |
| | d-Detailed item wise break up of all the bills | |
| | e-Report of Investigation/ Procedures done during treatment | |
| 8 | Claim Performa duly filled in all respect | |
| 9 | Application/Self Statement giving Circumstances under which he/she took treatment | |
| 10 | Others, if any | |
| | | |
| | | |

**Essentiality cum Emergency Certificate**

Northern Railway

Medical Department

I certify that Shri/Smt./Kumar/Kumari ……

Wife/Son/Daughter/Dependent relative of Shri/Smt…… .

Employed in Indian Railway as …… has been under my treatment for……disease from……to ……at the ……Hospital and 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.

Date: ……

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

Date: ……

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

**सभी बिलों की मद / तारीखनुसार सारांश**

**DETAIL OF DATE WISE / ITEM WISE BREAK UP OF ALL THE BILLS OF**

**(रोगी का नाम /Name of patient).....**

| क्र. सं.<br>Sr. No | दिनाक<br>Date | बिल संख्या<br>Bill No. | दवा विक्रेता/फर्म का नाम<br>Name of Chemist/Firm | मद का विवरण<br>Description of Item | मात्रा<br>Quantity | कीमत<br>Price |
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**प्राधिकृत चिकित्साधिकारी के हस्ताक्षर**

**Signature of Authorised Medical Officer**

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**चिकित्साधिकारी/अस्पताल के इंचार्ज के हस्ताक्षर**

**Signature of the Medical Office / Incharge of the case of the Hospital**

मै .....घोषणा करता हूँ/करती हूँ कि मैंने स्वयं/पत्नी/पुत्र/पुत्री/ आश्रित माता जी/बहन का उपचार .....रोग के लिए.....अस्पताल ..... में दिनांक.....से दिनांक.....तक करवाया है|

इस हेतु मैंने अपने या अपने किसी भी पारवारिक सदस्य हेतु कोई स्वाथ्य बीमा पालिसी इत्यादि नहीं ली है| इस रोग के उपचार के लिए व्यय की गई धनराशि एवम जिस समय अवधि का यह मामला मैं भुगतान हेतु प्रस्तुत कर रहा हूँ/कर रही हूँ, इस समय अवधि के इस केस/मामले में मैंने ना तो पहले कोई अभ्यावेदन भुगतान हेतु रेलवे विभाग या किसी अन्य निजी या सरकारी संस्था या बीमा कम्पनी इत्यादि को प्रस्तुत किया है एवं ना ही कोई धनराशि/ भुगतान प्रतिपूर्ति के रूप में रेलवे विभाग या किसी अन्य निजी या सरकारी संस्था या बीमा कम्पनी इत्यादि से प्राप्त की है एवम ना ही भविष्य में रेलवे विभाग या किसी अन्य संस्था या बीमा कम्पनी इत्यादि को भुगतान हेतु दावा प्रस्तुत करूंगा/करूंगी| यदि अभ्यावेदन कर्ता की यह घोषणा भविष्य में किसी भी स्तर पर झूठी पाई जाती है तो इसकी पूर्ण जिम्मेवारी अभ्यावेदन कर्ता की होगी एवम वह नियमो के अंतर्गत कार्यवाही के लिए उतरदायी होगा/होगी|

दिनांक.....

हस्ताक्षर .....

घोषणाकर्ता का नाम.....

पद.....

विभाग/स्टेशन.....

मोबाइल नम्बर.....