

**MEDICAL REIMBURSEMENT CLAIM FORM OF L.N.M.Rly.Hospital NER GKP**

1	Name of the Railway /Retd. employee (in BLOCK Letters)		Attach photo verified by Treating Doctor
2	Designation of Railway /Retd. employee(in BLOCK Letters)		
3	Office & Station of employment		
4	Pay/Last Pay of the Railway/ Retd. Employee including grade pay		
5	Residential address & phone Number		
6	MIC /RELHS no. & issuing Authority		
7	MIC /RELHS register at H. Unit/Hospital		
8	A Name & Age of the patient		
	B Patient's relationship to Rly./ Retd. employee		
9	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 (Attached Original bill)		
	F Weather Treatment was taken in Emergency:		
	G Are you a CTSE Member (Y/N):		
10	Whether you received any amount from Insurance Company for the treatment in question. Give amount and date .		
11	Total Amount Claimed	In Digits	Rs -
		In Words	
		Detail attached as annexure I	
12	Details of Bank Account where Reimbursement is to be paid:		
	a) Name of Bank.....	b) Account No. ....	
	c) Branch MIRC Code.....	d) IFSC Code. ....	
13	List of enclosures		
	A Photocopy of MIC/RELHS Card	B	Essentiality cum Emergency CertificateAnnexure II
	C Discharge Summary	D	Original Bills of Hospital
	E Original Cash Vouchers of Drugs/consumables/ Implants etc.	F	Outer Pouch of Stent, pacemaker, Implants
	G Any other enclosures		

**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 bonafied **student/ wholly dependent** upon me. I am aware that misuse of medical facilities or misrepresentation of any kind can attract penal action. I hereby declared that this is my final claim and I shall not make any claim in future to Railway or any other health scheme in respect to this treatment episode.

Place: \_\_\_\_\_ Signature of the Railway employee

Date: \_\_\_\_\_

Certified that the above information & declaration given by employees are correct.

Signature & Seal of the Controlling official

### Annexure –I (Details of the amount claimed )

Name Of Patient .....Relation with employee .....

Name & Designation of employee.....

#### I. Hospital Treatment & Medical Attendance:

i	consultation fee						
	S.N	Date of consultation	Doctors Name	specialty	Amount claimed	Amount Sanction	
ii	Charges for Investigation undertaken during diagnosis,						
	SN	Date	Name of investigation	Center of investigation	Advised by	Amount claimed	Amount Sanction
iii	Accommodation						
	Type		Period		Amount claimed	Amount Sanction	
			from	to			
	General						
	Semiprivate						
	Private						
iv	Diet						
	Period				Amount claimed	Amount Sanction	
	From		To				
v	Surgical operation or medical treatment						
	Date		Name of procedure				
v	Nursing charges						
	Period			Purpose		Amount claimed	Amount Sanction
	From		to				
vii	Ambulance charges						
	Date		Travel		distance	Amount claimed	Amount Sanction
			from	to			
viii	Others Non medicinal & Surgical Items						
	SN	Date	Invoice No	Name of Items		Claim Amount	Amount Sanction



**Annexure –II**  
ESSENTIALITY-CUM-EMERGENCY CERTIFICATE

I certify the \_\_\_\_\_ Husband /wife/son/daughter/  
dependent relative of \_\_\_\_\_ Designation & station \_\_\_\_\_, has  
been under my treatment for \_\_\_\_\_ disease from  
\_\_\_\_\_ to \_\_\_\_\_ at the \_\_\_\_\_ hospital  
and that the treatment as described in the attached discharge Ticket 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 and not a propriety  
preparation. The detail of patients and treatment are as follows.

A. Admission details.		
i	Date and time of admission.	
ii	Admitted through OPD service/ emergency service.	
iii	Admitted to an ICU bed or general bed or cabin bed.	
B. Clinical findings at the time of admission. Following findings should be made available and critically evaluated.		
i	Pulse rate.	
ii	B.P.	
iii	Level of consciousness	
iv	Any convulsive feature.	
v	Urine output	
vi	Any other feature of shock.	
vii	Body temperature	
viii	Extant of external wound	
ix	Extant of active bleeding.	
x	Extant of Chest pain or pain in other parts of the body.	
C. Types of medical treatment given immediately after admission.		
i	List of Emergency medicines used immediately after admission.	
ii	Type of surgical procedure done immediately after admission.	

Signature of the Treating Medical Officer  
Name and Stamp/Seal

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

## **INSTRUCTION FOR REIMBURSEMENT CLAIMS**

1	Reimbursement claim consisting of application of the employee, discharge death summary, bills, Annexure I , Medical Identity/RELHS card, legal affidavit if employee expired, Bonafied Certificate from school/college duly attested by the Gazetted Officer in case the patient is dependent son aged above 21 years .
2	Total amount claimed has to be rightly mentioned in the appropriate columns in the different heads of expenditure.
3	All forms where ever signature of the Medical Officer is mentioned are to be signed by the Treating Doctor along with his name stamp without which no claim will be entertained.
4	Original bills should be verified by the Treating Doctor without which no claim will be entertained.
5	Cash Memo & outer pouch in support of all claims including purchase of pacemaker, hearing aid and prosthesis duly countersigned by the doctor to be enclosed.
6	Reimbursement claim should be submitted within 6 months from the date of discharge.
7	In case the beneficiary has medical insurance policy and intent 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.
8	Referred treatment is only consider if the treatment is taken within one month of treatment.
9	Reimbursement of food supplement, vitamins, natural product, cosmetic product ,diaper, instruments not accepted
10	Reimbursement of medicine purchase after discharge is not permissible. Only permissible for period required for journey.