FORM C

Application Form for settlement of claim for reimbursement of W.B. Health Scheme

(See sub-clause(1) of clause 12)

(To be filled in by the applicant)

1	Identity Card(meant for the Scheme) No	:
2	Full Name of the Govt.employee with Designation (In Block Letters)	:
3	Full Address:-	:
	(i) Office	:
	(ii) Residence	:
4	Name of the Patient & Relationship with the Govt employee	:
5	Pay(Basic + Dearness Pay)	:
6	Name of the Hospital with Address	:
	(a) OPD treatment & Investigation	:
	(b) Indoor treatment & Investigation	:
7	Date of Admission:- _____ Date of discharge:- _____	
	(In case of Indoor Treatment Only)	:
8	Total Amount Claimed	:
	(a) OPD treatment	:
	(b) Indoor treatment	:
9	Details of permission	:
10	Details Medical Advance, if any	:

DECLARATION

I hereby declare that the statement 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 beneficiary of the West Bengal Health Scheme,2008, and the card issued under the Scheme was valid at the time of treatment. Igree for the reimbursement as is admissible under the rules.

Date **Signature of the Govt. Employee**

FORM D

Essentiality Certificate-cum-statement of Expenditure Certified by Treating Specialist

(See sub-clause(3) of clause 12)

(to be submitted in duplicate)

(Strike out whichever is not applicable)

1 **Name of the patient and Relationship with Govt.Employee** _____

2 **Details of expenditure**

(A) **OPD Treatment** **Disgnosis**

(I) **Name of the Hospital** _____

(II) **Total No. of vouchers** _____

(III) **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 wherever required)

		Amount Claimed	Amount Admissible (For Official Use)
(a)	Medicine		
(b)	Consultation fees (Specify number of consultations)		
(C)	Laboratory charges (Break-up in a separate annexure)		
(d)	Disposable surgical Sundries		
(e)	Special devices like hearing aid/ artificial appliances etc.(specify)		
(f)	Miscellaneous(specify)		
	TOTAL Rs.		

Cont.page 2

(B) Indoor Treatment **Diagnosis**

(To be marked N.A. wherever not 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 number of individual vouchers with name and address of shops with date against each sub-heading in a separate annexure wherever required)

		Amount Claimed	Amount Claimed
(i)	Room Rent (ICU/ICCU/Ward From To		
(ii)	Charges for :-		
	(a) O.T.		
	(B)O.T.Consumables		
	(c) Anesthesia		
	(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 Annecure)		
(vii)	Spl.Nurse/Ayah, if any		
(viii)	Miscellaneous		
	Total Rs		

(Signature of Claimant)

Name in Block Letters

Address

1 **Certified that the relevant bills/vouchers have been verified by me and the expenditure shown above is correct & the treatment services provided are essential & minimum that required for the recover of the patient.**

2 **Certified that the services of Special Nurse/Ayah were required from _____To_____ that were absolutely essential for the recovery of the patient.**

3 **Specific procedure/Operation performed was**

Countersigned by Medical Superintendent of the Hospital with Seal(For Indoor treatment only)

Signature of the Treating Specialist with official seal

FORM E

Checklist for Reimbursement of Medical Claims

(See sub-clause(3) of clause 12)

1	Card No. and place of issue	:	
2	Entitlement		Private Semi-Private General Ward
3	Full Name of Card Holder Govt.Employee(In Block Letters)	:	
4	Designation	:	
5	The following documents are submitted	:	
	(Please tick[√] the relevant column)	:	
	(a) Photocopy of the Identity	:	Yes/No
	(b) Essentiality Certificate	:	Yes/No
	© Number of original bills	:	Yes/No
	(d) Whether original bills/vouchers have been verified	:	Yes/No
	(e) Copy of discharge summary	:	Yes/No
	(f) Copy of permission letter	:	Yes/No
	(g) Whether the Hospital has given break up for lab investigations	:-	Yes/No
	(h) Original papers have been lost the following documents are submitted	:	Yes/No
	(I) Photocopies of claim paper	:	Yes/No
	(II) Affidavit on stamp paper	:	Yes/No
	(i) In case of death of card-holder the following documents are submitted	:	
	(I) Affidavit on stamp paper 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 the Applicant

FORM - F

Temporary Family Permit

[See sub-clause(9) of clause 10]

1 **Name of the Govt. employee :**

2 **Employee Code No.(G.P.F.A/C No.) :**

3 **Designation :**

4 **Present Pay (Basic Pay + Dearness Pay):**

5 **Entitlement of Accommodation :**

6 **Date of Birth :**

7 **Date of Superannuation :**

8 **Residential Address :**

9 **Details of Falily :**

Sl.No	Name	Age	Relationship	Monthly Income,if any
1				
2				
3				
4				
5				

Shri/Smt……attached to……..

(Office) under ……..Department has been enrolled under the West Bengal Health Scheme, 2008 with effect from ……..

He/She and his/her family members are entitled to the medical attendance and treatment in a Govt. Hospital/ enlisted Pvt.Hospital or Institution etc. in the entitled class mentioned in Sl. No. 5.

This permit is valid for 6(six) months from the date issue.

Signature of Cadre Controlling Authority/Head of the Office