## 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 .......... 
3. Full name of Card Holder (Block Letters): 
4. Status (Govt Servant/Pensioner/Other): 
5. The following documents are submitted (Please tick (-/) the relevant column): 
   - Yes/No.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Medical 2004 Form.</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>Photocopy of CGHS card</td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td>Essentiality Certificate</td>
<td></td>
</tr>
<tr>
<td>(d)</td>
<td>No. of Original Bills</td>
<td></td>
</tr>
<tr>
<td>(e)</td>
<td>Whether original bills/ vouchers have been verified</td>
<td></td>
</tr>
<tr>
<td>(f)</td>
<td>Copy of discharge summary</td>
<td></td>
</tr>
<tr>
<td>(g)</td>
<td>Copy of Permission letter</td>
<td></td>
</tr>
<tr>
<td>(h)</td>
<td>Whether the hospital has given breakup for lab investigations</td>
<td></td>
</tr>
<tr>
<td>(i)</td>
<td>Original papers have been lost the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Following documents are submitted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I. Photocopies of claim papers</td>
<td>Yes/No.</td>
</tr>
<tr>
<td></td>
<td>II. Affidavit on Stamp Paper</td>
<td>Yes/No.</td>
</tr>
<tr>
<td></td>
<td>(j) Incase of death of card holder the following documents are submitted,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I. Affidavit on Stamp paper by Claimant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>II. No objection from other legal Heirs on Stamp papers</td>
<td>Yes/No.</td>
</tr>
<tr>
<td></td>
<td>III. Copy of death certificate</td>
<td>Yes/No.</td>
</tr>
</tbody>
</table>

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 REIMBURSEMENT OF MEDICAL CLAIMS OF CGHS BENEFICIARIES.

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).

***************

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 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 whenever required).

<table>
<thead>
<tr>
<th>Amount Claimed</th>
<th>Amount Admissible (for official use.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Medicine</td>
<td></td>
</tr>
<tr>
<td>(b) Consultation fees (specify number of consultations.</td>
<td></td>
</tr>
<tr>
<td>(c) Laboratory Charges (Break-up In a separate annexure.)</td>
<td></td>
</tr>
<tr>
<td>(d) Disposable Surgi Sundries.</td>
<td></td>
</tr>
<tr>
<td>(e) Special devices like hearing aid/artificial appliances etc. (Specify).</td>
<td></td>
</tr>
<tr>
<td>(f) Miscellaneous (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
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<th>Amount admissible</th>
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<td>Amount admissible (for office use)</td>
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</table>

(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).