Documents to be attached

1. Photo copy of the CGHS card of the employee along with the patient's 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, Affidavits 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,

c) In case of implants, Invoice No. along with sticker with serial number of the implant to be attached.

d) In case of Coronary Stents, outer pouch of stents is to be enclosed.

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 willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of 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 Ben ID No. :
   (c) Employee Code No. :
   (d) Ward Entitlement – Pvt./Semi-Pvt./General :
   (e) Full Address :

   (f) Mobile telephone No. and e-mail address, if any :

2. (a) Patient's Name :
   (b) Patient's CGHS Ben 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 & 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/Investigation :

11. Name of the Bank : ..... SB A/c No.: .....
    Branch MICR Code: ..... IFSC Code.....

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 dependent 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 : .....

Place: .....

Signature of the Principal CGHS card holder