REIMBURSEMENT CLAIM FORM

1.Name of the Railway/retd. employee (in BLOCK letters) _____

2. Designation of the Railway retd. employee (in BLOCK letters) _____

3. Office and Station of employment _____

4. Pay/Last Pay of the Railway/retd. employee including grade pay_____

5. Residential address _____ _____

_____

_____

_____

6. MIC/RELHS no. and issuing Authority _____

7. MIC/RELHS registered at Health Unit Hospital _____

II.(A) Name and age of the patient _____

(B) Patient's relationship to the Railway/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 CTSE 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 _____

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

A. Photocopy of MIC/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 enclosures_____

(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 or 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 Rly or any other health scheme in respect to this treatment episode.

Signature of the Railway employee

Date:

Place:

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.

_____Railway

MEDICAL DEPARTMENT

ESSENTIALITY AND EMERGENCY CERTIFICATE

I certify that Shri/Shrimati/Kumar/Kumari _____ wife / son / daughter / dependent relative of Shri / Shrimati_____ employed in Indian Railway as _____has been under my treatment for _____ disease from _____to _____at the _____hospital and that 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.

_____

Signature of the Medical Officer
In charge of the case at the non-Railway hospital
with Name and Stamp / Seal

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