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 H Unit/Hospital……..

II (A) Name and age of the patient ……..
II (B) Patient's relationship to the Rly/Retd. Employee……..
III Detail's 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. a) Whether subscribing to any **Health insurance Policy** or covered under any other health scheme:
b) Whether any **advance payment** was processed for this claim, if yes details thereof.

(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._____
b. 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 enclosure……

(In case of many enclosures, write number of additional enclosures here and attach separate sheet with details)

DECLARTATION TO BE SINED 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 misuses of medical facilitate 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.

Date :
Place :

Incharge

Signature of the Railway Employee.

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 Rly. With documents, bills etc. attested by insurance company.

NORTHERN RAILWAY
MEDICAL DEPARTMENT
ESSENTIALITY cum EMERGENCY CERTIFICATE

I certify that Shri/Shimati/Kumara/Kumari_____wife /son/ daughter / dependent_____relative of Shri / Shirmati_____, 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

PART 'C'

I hereby certify that Sh./Kumari ---------- ----------wife /son daughter ----------of ---------- Employed in the ----------has been under treatment for ----------to ----------at the ----------hospital and that the facilities' provide were the minimum which were essential for the patient's treatment.

Date:-
Place:-

----------hospital

ANNEXURE 'C'
NORTHERN RAILWAY

To establish the emergency condition following parameters are to be examined on:-

Admission details:

(i) Date and Time of Admision :
(ii) Admitted through OPD service/ Emergency service :
(iii) Admitted to an ICU bed/general Bed or cabin bed :

Clinical finding at the time of admission:

Following findings should be made available & critically evaluated

(a) Pulse rate :
(b) B.P :
(c) Level of consciousness :
(d) Any convulsive feature :
(e) Urine Output :
(f) Any other feature of stock :
(g) Body temperature :
(h) Extent of external wound :
(i) Extent of active bleeding :
(j) Extent of Chest of pain of pain In other part/s of the body :

Type of medical treatment given immediately after admission:

(a) List of Emergency medicines used Immediately after admission
(b) Type of surgical procedure done Immediately after admission

Signature of the treating Doctor

सभी बिलों की मद/ तारीखनुसार सारांश

DETAIL OF DATE WISE/ITEM WISE BREAK UP OF ALL THE BILLS OF

(रोगी का नाम /Name of patient……………………………………………………………………………)

क्र. सं. Sr. No.	दिनाक Date	बिल संख्या Bill No.	दवा विक्रेता/फर्म का नाम Name of Chemist/Firm	मद का विवरण Description of Item	मात्रा Quantity	कीमत Price

…………………………………………………

प्राधिकृत चिकित्साधिकारी के हस्ताक्षर
Signature of Authorised Medical Office

……………………………………………………………………

चिकित्साधिकारी/अस्पताल के इंचार्ज के हस्ताक्षर
Signature of the Medical Office/Incharg
The case of the Hospital