List of Documents for Reimbursement Claim			
Sr.No	**Technical Documents**	**Yes/No**	**Page. No**
1.	Annexure VI completely filled. Strike Out whatever is not applicable		
2.	Whether case referred by Railway Authority, If yes attach referral paper		
3.	Annexure-III-Certificate "A" form for investigation only(for non Admitted cases) [if not admitted]		
4.	Original hospital bill duly verified by treating private doctor		
5.	Original Medicine bills duly verified by treating private doctor		
6.	Original Investigation bills duly verified by treating private doctor		
7.	Original Investigation reports		
8.	Hospital bill detail breakup		
9.	investigation bill detail breakup		
10.	Lab bill detail breakup		
11.	Original Emergency certificate issued by treating private doctor		
12.	Original Discharge Card/Summary/Death Summary.		
13.	Railway Hospital case Papers.		
14.	Private Hospital case Papers.		
15.	Claimed amount in tabular form		
	Non-Technical Documents		
1.	Forwarding letter from concerned department/certification		
2.	Application from employee/claimant(in detail)		
3.	Whether patient is dependent upon the Railway employee, if yes attach necessary documents.(MRC-2)		
4.	Delay condonation by controlling officer if claim submitted after six months of treatment		
5.	Medical Identity Card/RELHS Card(attested photo copy)		
6.	NEFT/RTGS Form with signature and stamp of bank.		
7.	Pay slip (For serving employee)/PPO Book(attested photo copy for retired Employee)		
8.	Copy of cancelled blank Cheque.		

Signature of Claimant

Annexure-VI

(See Para 648)

Proforma for submission of claim for reimbursement of medical expenses incurred by Railway Employee for treatment in Private Hospital/Non-Recognized Institutions.

1.	Name of the Patient	:	
2.	Age	:	
3.	a) Relationship with Railway Employee. b) Name of the Employee.	:	
4.	Designation	:	
5.	Pay	:	
6.	Name of the Institution where taken for treatment	:	
7.	Date of Admission	:	
8.	Date of Discharge	:	
9.	Date of Admission of claim	:	
10.	Reasons for Delay	:	
11.	Total period of stay as indoor patient	:	
12.	Reasons for long stay(if stayed for more than 48 hours)	:	
13.	Type of medical emergency	:	
14.	Was there no Railway /Govt facility available to deal with it.	:	
15.	Distance of the nearest Govt Hospital and whether facilities available there.	:	
16.	Distance of the nearest Railway Hospital and whether facilities available there. if not how far is the Railway hospital with the facilities available	:	
17.	Distance of the Private Hospital, where facilities availed from residence/Place of illness	:	
18.	When the Railway Medical Officer was informed about such admission.	:	
19.	Did the patient take any treatment before or after the present sickness(if this existed and if YES when____)	:	
20.	Total amount claimed (with breakup charges)	:	Rs
21.	Item wise breakup of expenditure had the treatment been taken in a Govt. Hospital	:	
22.	Verbatim views of C.M.D	:	
23.	Verbatim views of F.A &C.A.O	:	

Annexure-III- Certificate for investigation only (for non Admitted cases)

CERTIFICATE-A-

(To be completed in the case of patients who are not admitted to hospital for treatment)

1. Name and designation of the Railway Employee
   (In BLOCK letters) _____.
2. Office in which employed _____.
3. Pay of the Railway Employee _____.
4. Place of the duty _____.
5. Actual Residence address _____.
6. Name of the patient and
   his/her relation to the employee _____.

Note: In case of children, state age also

7. Place at which patient fell ill _____.
8. Nature of illness and its duration _____.
   a) That the injections administered were not for immunizing or prophylactic, purposes.
   b) That the patient has been under treatment at_____hospital/dispensary and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the _____(name of hospital/dispensary)
   For supply to private patients and do not include proprietary preparation for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants.

Name of medicines	Price
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

A) That the patient is/was suffering from _____ and is/was under my treatment from _____ to _____.

B) That the patient was given pre-natal or post-natal treatment.

C) That the X-ray, laboratory tests, etc, for which an expenditure of Rs_____/- was incurred were necessary and were undertaken on my advice a _____(name of hospital or laboratory).

D) That I referred the patient to Dr _____ for specialist consultation and that the necessary approval of the Dr._____(name of the principal Medical officer) as required under the rules was obtained .

E) That the patient did not require hospitalization.

Signature and designation of
the Medical Officer

Date:

Place:

Note: certificate not applicable should be struck off. Essentiality certificate as given in (b) as above is compulsory and must be filled in by the Medical Officer in all cases.

Medical reimbursement claim of Shri/Smt_____

Design:-_____

Tabular form for Various charges.

Hospital Bill/Charges paid (Table"A")

Sr.No	Page No.	Receipt No.	Date	Charges

Pathology/Investigation Charges paid (Table"B")

Sr.No	Page No.	Receipt No.	Date	Charges

Medicine Charges paid (Table"C")

Sr.No	Page No.	Receipt No.	Date	Charges

Total charges Paid A+B+C+D	
Signature of Applicant	

ANNEXURE –IV CUM REIMBURSEMENT CLAIM FORM

1. Name of Railway /Retd employee (in BLOCK Letters):_____
2. Designation :_____
3. Office & Station of Employement :_____
4. Department :_____
5. Pay/last Pay of Rly Employee(With ML) :_____
6. Residential Address :_____

_____

_____

_____

7. MIC/RELHS/UMID No.& Issuing Authority :_____
8. MIC/RELHS/UMID registered at HU/Hospital :_____

II(A) Name & Age of the Patient :_____

II(B) Patient's relationship to the Rly/Retd.employee :_____

III Details of Indoor Treatment at Non Railway Institute:

A. Name of Hospital where treatment availed :_____
B. Date of Admission :_____
C. Date of Discharge :_____
D. Diagnosis :_____
E. Amount of Total Hospital Bill(Attach Bill) :_____
F. Whether Treament was taken in emergency :_____
G. Are you a CTSE Member(YES/NO) :_____

IV. Whether subscribing to any Health Insurance Policy or covered any other health scheme. If yes have you received any amount from Insurance Company for the treatment in question? If any on separate sheet of paper (Yes/No) :_____

V. Total Amount Claimed :_____

VI. Details of Bank Account where reimbursement amount is to be paid:

a. Name of Bank:_____ Account No:_____

b. Bank MICR Code:_____ IFSC Code:_____

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

A. Photocopy of MIC/RELHS card(Attested Copy).
B. Essentiality cum Emergency Certificate by the non Railway Hospital.

C. Original Discharge /Death Summary (To be signed with Stamp, Name& Registration Number of Treating Doctor).

D. Original Bills of Hospital (To be Stamped & signed by Hospital Authority).

E. Original Cash Vouchers of Drugs/Medicine, if relevant (To be Stamped & signed by Treating Doctor).

F. Outer pouch of stent, pacemaker, Implant etc.

G. Any other enclosures_____

H. No Claim Certificate.

I. Attach Xerox copy of Bank (Pension A/C) cheque/Bank Passbook for payment for retired Employee.

J. Consolidated Claim Amount Statement.

DECLARATION TO BE SIGNED BY THE RAILWAY EMPLOYEE

I hereby declared 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 depend upon me. I am aware that misuse of medical facilities or misrepresentation of any kind can attract penal action including cancellation of my MIC/RELHS card. I hereby declared that this is my final claim and I shall not make any claim in future to Railway or any other health scheme in respect to this treatment episode.

Date: _____ Signature of the Railway employee

Place: _____ Contact No._____

In case of 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.

TREATING DOCTOR

ANNEXURE-V
Central Railway
Medical Department
Essentiality cum Emergency Certificate

I certified that Shri/Smt/Kumari_____wife/son/daughter/dependent relative of _____ employee 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._____
Dated_____ and attached bill thereon were provide due to an emergency situation, treatment for which could not have been delayed. I further certify that treatment provided was essentially required.

Date:-

Signature of the Medical Officer
Incharge of Rly/Non Rly Hospital
Place:- **With name and stamp/seal &Registration No.**

Hospital Seal

****

Clinical Findings

Admission details:-

i) Name of the patient:-
ii) Admitted through OPD Emergency service
iii) Admitted to an ICU bed or General bed or cabin bed:-

Clinical finding at the time of admission following should be made available and critically evaluated:-

1) Pulse rate :-
2) B.P :-
3) Level of consciousness :-
4) Any Convulsive :-
5) Urine output :-
6) Any other feature of shock :-
7) Body temperature :-
8) Extant of external wound :-
9) Extant of active bleeding :-
10) Extant of chest pain or pain in other parts of the body :-

Type of medical treatment given immediately after admission :-

i) List of emergency medicines used immediately after admission:-

ii) Type of Surgical procedure done immediately after admission:-

Date:-

Signature of the Medical Officer
Incharge of Rly/Non Rly Hospital
With name and stamp/seal &Registration No.

Place:-

Hospital Seal

SELF DECLARATION

I under signed _____ declared that the treatment availed in (Hospitalname)_____

For Myself/Wife/Husband/Daughter/Son/Dependent Mother for the period from _____ to_____ and the expenditure occurred for this aforesaid period claimed amount Rs._____ is not claimed from any other source(medical Insurance, Donation and Institution).The medical reimbursement claim for the treatment on said period and bills is claimed at Railway only.

I hereby declare that the statement in this application is true to the best of my knowledge and belief and that the claim for whom medical expenses were incurred is wholly dependent upon me. If any false/incorrectness is found, I may be liable for DAR as per extent Rules of Railway Administration.

I hereby also declare that :-

1. I am aware of the CGHS Rules, guidelines and rates. I have no objection to settlement of my claim as per CGHS rates and extent Rules.
2. If any variation found in my calculation of total claim amount due to my mistake(like adding advance receipt, bills out of date, concession, discount etc.)
3. I had not been claimed any hearing Aids, CPAP, BI-CPAP, Oxygen Concentrator the preceding last five years for myself or dependent.(In case of advised by Rly Doctor).
4. In case of IVF(FIRST/SECOND/THIRD Cycle(_____)

Place:-

Date:-

Signature of the Railway Employee/Claimant

Design:-_____

Office:-_____

Department:-_____

Details of insurance amount received, If any (Yes/No)

_____

_____

_____

CONSOLIDATED CLAIM AMOUNT STATEMENT

- Name of Claimant:_____
- Design &Office_____Department:_____
- Hospital Name:_____
- Date of Admission_____Date of Discharge:_____
- Name of Patient:_____Relation:_____

(Date of Admission to Date of Discharge period is bills claimable only)

Sr.No	Particulars	Amount (Rs.)
1.		
2.		
3.		
4.		
	Grand Total	

Total Amount in (Words)_____

_____ /-

I hereby declared that above mentioned claim is FULL and FINAL.

Signature of Claimant

Name:_____

Sr.Divisional Finance Manager
Central Railway,
Solapur
Pin-413001
Tel-Fax No 021/2311164

RTGS/NEFT FORM

I hereby agree to get make my payment through NEFT/RTGS

1.	Name of Employee/Pensioner as per Bank Account	
2.	Name of Bank	
3.	Branch name	
4.	Bank Account Number of Employee/Pensioner	
5.	IFSC Code of Bank	
6.	MICR code of Bank	
7.	Address of Bank	
8.	Telephone No. of Bank	
9.	Email Id of Bank	
10.	Address of Employee/Pensioner	
11.	Telephone No of Employee/Pensioner	
12.	Mobile No of Employee/Pensioner	
13.	Email of Employee/Pensioner	

I hereby certify that above information is correct & true to my knowledge.

Signature of Employee/Pensioner

List of Documents Required For Medical Reimbursement Claim

1) **ANNEXURE –IV CUM REIMBURSEMENT CLAIM FORM(2pages).**
2) **ANNEXURE-V (Essentiality cum Emergency Certificate & Clinical Findings)**
3) **SELF DECLARATION by Claimant.**
4) **CONSOLIDATED CLAIM AMOUNT STATEMENT**
5) **RTGS/NEFT FORM(Duly Signed by Bank Manager with Bank Seal)**

List of Enclosures Required to be Attach along with Medical Reimbursement Claim

1) **Photocopy of MIC/RELHS card(Attested Copy).**
2) **Payslip (Attested copy For Serving Employee)/PPO Book (Attested copy For Retired Employee)**
3) **Original Discharge /Death Summary (To be signed with Stamp, Name& Registration Number of Treating Doctor).**
4) **Original Bills of Hospital (To be Stamped & signed by Hospital Authority).**
5) **Original Cash Vouchers of Drugs/Medicine, if relevant (To be Stamped & signed by Treating Doctor).**
6) **Outer pouch of stent, pacemaker, Implant etc.**
7) **No Claim Certificate (If Any).**
8) **Attach Xerox copy of Bank (Pension A/C) cheque/Bank Passbook for payment for retired Employee.**
9) **Cancelled Blank Cheque.**
10) **Delay Condonation by controlling officer if claim is submitted after Six Months Of Discharge.**

Note:- MRC Form Available At Xerox Centre of DRM/SUR office.