

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 garde pay
- 5. Residential address
- 6. MIC/RELHS no. and issuing Authority
- 7. MIC/RELHS registered at H Unit/Hospital

I (A) Name and age of the patient

II (B) Patient's relationship to the Rly/Retd. Employee

III Details of Indoor/OPD 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 Policy¹ or covered under any other health scheme:
If yes, have your 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 the 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 enclosure

(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.

Date

Place

.....
Signature of the Railway employee

¹In 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.

..... RAILWAY

MEDICAL DEPARTMENT

ESSENTIALITY cum 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