REIMBURSEMENT CLAIM FORM

1. Name of the Railway/ Retd, Employee (in Block letter) ____________________
2. Designation of the Railway/ Retd. employee (in Block letter) ____________________
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 ____________________

A. Name and age of the patient ____________________

B. Patient's relationship to the Rly /Retd. Employee ____________________

Details of Indoor treatment at Non Railway Institute

A. Name of the 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 CSTSE member (Y/N):-

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 separate sheet of paper.

Total Amount claimed:-

Details of Bank account where Re-imbursement amount is to be paid:

A. Name of Bank:-

B. Account No:-

C. Branch MICR Code:-

D. IFSC Code:-

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EAST CENTRAL RAILWAY

MEDICAL DEPARTMENT
ESSENTIALITY cum EMERGENCY CERTIFICATE

I certify that Shri/Smt/Kumar/Kumari ______________________________ wife/ daughter/ dependent relative of Shri/ Smt ______________________________, 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

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II. List of enclosure (Please Tick the document attached and write additional document)

A. Photocopy of MIC/RELHS card

B. Essentiality cum Emergency Certificate by the Non Railway 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, pacemakers, implants etc.

G. Any other enclosure ____

____

(In case of many enclosure, write numbers of additional enclosures here and attach a separate sheet with details.)

DECLARATION TO BE SIGNED BY THE RAILWAY EMPLOYEE

I hereby declare that the statement 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 of 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 Railway or any other health scheme in respect to this treatment episode.

____

Date:- Signature of the Railway Employee

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 to Railway with documents, bills etc. attested by insurance company.

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