### Government of West Bengal Finance Department Medical Cell

No.: 78-F(MED)WB

Dated : 22/10/2019

### MEMORANDUM

# Sub : Introduction of revised "Reimbursement Claim Forms" of West Bengal Health Scheme

Employees / Pensioners / Family Pensioners submit their reimbursement claim under West Bengal Health Scheme in the specified forms circulated vide order no. 6953-F(MED), dated; 11.07.2011 attaching essential documents required for such reimbursement.

West Bengal Health Scheme Portal has been upgraded and various services and process have been made online. Now various applications by employees / pensioners and family pensioners can be made online and Heads of Offices and DDOs can perform various functions, processing and approval online.

"Application Forms" have been modified to make them simpler and compatible with online mode.

After careful observation, the Governor is pleased to abolish all the existing forms and introduce **revised physical Application Forms** and also introduce **online reimbursement claim forms** of each category of the following:

- i. Form-C1 [Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital].
- ii. **Form-C2** [Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital].
- iii. **Form-C3** [Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital].
- iv. **Form-C4** [Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital].

An Employees / Pensioner / Family Pensioner have to now submit the claim for reimbursement of expenditure incurred for treatment under WBHS in these revised forms only.

This order shall come into effect from the date of issue of this order.

Enclosures : As stated

(Parwez Ahmad Siddiqui) Secretary Finance Department

# Manual/ Offline Reimbursement Application Form

# Form -C1

### Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

## under West Bengal Health Scheme

<u>(Applicable for those who are not able to claim through online by himself/herself and online entry shall</u> have to be done by the office of Head of Office)

### Part-I[General Information]

1. Details of Employee/Pensioner.								
Full Nam	е			H	RMS ID / PPO	No.		
(in Block	letters)							
Enrollme	ent ID No.			C	laim Applicatio	on ID.		
					o be filled at t			
					nline entry fro	-		
					f Head of Offic			
2. D	etails of Patie	nt, Treating Hospital	and Condo	nati	ion Requireme	ent, if any.		
2.1	Name of Patier	nt						
2.2	Name of Empa	nelled/Enlisted hospita	l where					
	treatment was availed.							
2.3	Requirement	of approval of delay (	Condonatio	٦,	Yes 🗆	No□	Not known□	
	if any(Tick mar	k in appropriate box)						
3. D	etails of Claim	ant (Applicable in cas	se of death	of e	mployee or pe	nsioner or	family pensioner )	
SI. No.		Name of claimant		Relation			ion	
3.1								
4. P	ermission Det	ails, If any						
SI. No.	Perm	ission sought	De	tails	s of permissior	n approval		
4.1	For treatmer	t availed in enlisted						
	hospital outside West Bengal Date:							
	Designation / Authority :							
	dated 19.09.	•	U.O. No. a		-			
			Finance De	eptt	. West Bengal	, if any:		

### Part-II [Details of Expenditure Statement of OPD treatment]

5. D	5. Details of OPD Treatment								
SI. No.	Particulars	Details							
5.1	Category of OPD Claim (Tick mark in appropriate box)[See list of diseases/illness mentioned in clause 7(1) and 7(2)]			As per claus of OPD List	e 7(2)				
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment								
5.3	Date of OPD consultation								
6. E	6. Expenditure Statement of OPD treatment								
SI.	Name of Components Amount								

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No.	No.						
6.1							
6.2							
6.3	Cost of Medicines						
	Period of medicine consumption	From		То			
6.4	Cost of Special Device						
6.5	5.5 Miscellaneous (specify)						
Total							
No. of Vouchers							

### Part-III [Medical Advance]

7. Details of Medical Advance, if any								
Name of Treasury from	DDO	Designation of	Treasury	Treasury	Amount			
where it was drawn	Code	DDO	Voucher No.	Voucher Date	(Rs.)			

#### Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any								
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount			
where it was drawn	Code		Challan No.	Challan Date	(Rs.)			

Net Claim: [Part-II minus Part III] or [Part-II minus Part-III plus Part IV]					
Rs. ;	In words; Rupees				

### Part-V [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Sl. No.	Name/Particulars of enclosures to be attached Enclosed or not			
1	Annexure-I duly signed with proper stamp by Treating Specialist of an			
	Empanelled/Enlisted Hospital	Yes 🗆	No 🗆	
2	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆	
3	Money Receipts in sequentially	Yes 🗆	No 🗆	
4	Copy of OPD Prescription	Yes 🗆	No 🗆	
5	Copy of permission granted if any	Yes 🗆	No 🗆	
6	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes 🗆	No 🗆	
7	Copy of all investigation/ test reports in sequentially.	Yes 🗆	No 🗆	

# Manual/ Offline Reimbursement Application Form

8	In case of death of Employee, Pensioner and Family Pensioner;		
	a. An, affidavit on stamp paper by claimant	Yes 🗌	No 🗖
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No 🗆
	c. Copy of death certificate	Yes 🗆	No 🗆
9	Filled ECS mandate form in case of those, whose bank details is not		
	available in IFMS (in case of first claim only)	Yes 🗆	No 🗆
10	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant:				
Name in Block Letters	:			
Designation/Last Designation	:			

# Manual/ Offline Reimbursement Application Form Form –C2

# Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital

### under West Bengal Health Scheme

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

### Part-I[General Information]

1.	1. Details of Employee/Pensioner.							
Full Name			HRM	HRMS ID / PPO No.				
(in Blo	ck letters)							
Enrollr	nent ID No.		Claim	Application	ID			
			(To b	e filled at the	time of			
			onlin	e entry from e	end the			
			Head	of Office)				
2.	<b>Detail of Patient</b>	, Treating Hospital and Condon	ation	Requirement	:, if any			
2.1	Name of Patient							
2.2	Name of Non-En	npanelled/hospital where treatr	nent					
	was availed.							
2.3	Requirement of	approval of delay Condonation,	if	Yes 🗆	No□	Not known□		
Any (Tick mark in appropriate box)								
3.	<b>Detail of Claima</b>	nt (Applicable in case of death o	of emp	loyee or pens	ioner or far	mily pensioner)		
SI. No.		Name of claimant			Relation			
3.1								

### Part-II [Details and Expenditure Statement of IPD treatment]

4. Per	4. Period of treatment							
	Admission Date			Discharge Date				
5. Тур	5. Type of Discharge							
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box			
5.1	Normal		5.3	Referral				
5.2	Risk Bond		5.4	Death				
6. Am	ount Claimed for							
SI. No.		Tick mark in appropriate box						
6.1	Only Procedural/ Packa							
6.2	Only Non- Procedural/							
6.3	Both Procedural/ Packa	ige and Non- Procedu	ural/ Packa	ge Treatment				
6.1 Det	ails of Procedural/ Pack	age Treatment						
	Period of Procedural/ Pa	ackage Treatment	From		То			
SI. No	Na	ame of Procedures/ F	Packages		Amount Claimed (Rs.)			
6.1.1								
6.1.2								
6.1.3								
6.1.4								

## Manual/ Offline Reimbursement Application Form

6.1.5							
				Total			
6.2 Det	ails of Implants Used						
Sl. No.	Sl. No. Name of Implants						
						(Rs.)	
6.2.1							
6.2.2							
6.2.3							
6.2.4							
				Total			
	ils of Non-Procedural/ Package T				1		
	Non-Procedural/ Package Treat		From		То		
SI. No.	Name	of Component	ts		Amo	unt Claimed (Rs.)	
6.3.1	Room/ Bed Rent						
	ICCU/ITU/ICU/NICU/PICU	From	То		1		
	HDU/SDU	From	То				
	Burn Unit	From	То				
	CRIB	From	То				
	General/Semi-Private/Private	From	То		-		
6.3.2	Consultation Fees						
6.3.3	Pathological and Radiological Inv	vestigations					
6.3.4	Medicines						
6.3.5	6.3.5 Consumables						
6.3.6	6.3.6 Special Nursing/Aya Charges						
6.3.7	Miscellaneous. (If Any Specify)						
				Total			
			1	lo. of Vouchers			
		Total Tre		t [6.1+ 6.2+6.3]			
L					1		

Net Claim:(Part-II)	
Rs. ;	In words; Rupees

### Part-III [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

SI.	Name/Particulars of enclosures to be attached	Enclosed or not
-----	---	-----------------

# Manual/ Offline Reimbursement Application Form

No.			
1	Annexure-II duly signed with proper stamp by the Medical	Yes 🗆	No 🗆
	Superintendent of a Non-Empanelled Hospital		
2	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆
3	Bill Summary	Yes 🗆	No 🗆
4	Money Receipts in sequentially	Yes 🗆	No 🗆
5	Copy of Discharge Summary (Case summary in case of death) and OT note and copy of death certificate	Yes 🗆	No 🗆
6	Detailed Bill	Yes 🗆	No 🗆
7	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes 🗆	No 🗆
8	Copy of all investigation/ test reports in sequentially	Yes 🗆	No 🗆
9	Copy of OT Note in case of procedural/package treatment and	Yes 🗆	No 🗆
	treatment summary or bed head ticket in case of non- procedural/package treatment		
10	In case of death of Employee, Pensioner and Family Pensioner;		
	a. An affidavit on stamp paper by claimant	Yes 🗆	No□
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No□
	c. Copy of death certificate	Yes 🗆	No□
11	Filled ECS mandate form in case of those, whose bank details is not	Yes 🗆	No 🗆
	available in IFMS (in case of first claim only)		
12	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

## Signature of the Employee/Pensioner/Claimant:

Name in Block Letters	:
Designation/Last Designation	:

### Form –C3

# Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital

### under West Bengal Health Scheme

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

### Part-I[General Information]

1. D	1. Details of Employee/Pensioner					
Full Na	ame			HRMS ID	) / PPO No.	
(in Block	(letters)					
Enroll	ment ID No.			Claim Ap	plication ID.	
					l at the time of	
				online entr Head of Of	y from the end of fice)	
2. <b>D</b>	etails of Patie	nt, Treating Hospital and Cor	ndona		,	
2.1	Name of Pati	ent				
2.2	Name of Emp	panelled/Enlisted hospital				
	where treatn	nent was availed				
2.3	Requirement	of approval of delay	Yes	S No	] N	lot known□
	Condonation	, if any (Mark in appropriate				
	box)					
3. D	etails of Claim	nant (applicable in case of dec	ath of	employee or pensio	ner or family p	ensioner)
SI. No		Name of claimar	nt		Re	lation
3.1						
4. P	ermission Det	ails (If any)				
Sl. No	. Per	mission sought		Details of	permission ap	proval
4.1	For treat	tment availed in empane		nelled Permission ID :		
	private h	ospital within West Benga	l[see	Permission approved	l for:	
	clause 14	of Order No. 796 and 797, a	dated			
		11253-F(MED), dated; 16.12.2011	and			
	7578-F(MED	) dated;04.09.2012]				

#### Part-II [Expenditure Statement of IPD treatment]

5. Detai	5. Details of Treatment in Cashless Mode								
Sl. No.	Particulars			Details					
5.1	Transaction ID of Cashless	Treatment							
	(See Form-H or D4 supplied by h	ospital at the time of a	lischarge)						
5.2	Treatment Period	Admission Date		Discharge Date					
5.3	Total Treatment Cost (Rs.)								
5.4	Cashless Admissible Reimbur	sement Certificate (	CARC)No.						
5.5	Amount paid to hospital (F	Rs.)							
5.6	Amount admissible for rein	mbursement agains	st CARC(Rs.)						
	(See Row no. 16 of CARC g	enerated through s	ystem)						
	Total Claim of Indoor Cashless Treatment (Rs.)								
		(amount mei	ntioned in 5.6)						
	Total no	os. of Vouchers/Mo	ney Receipts						

#### Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

	The in [Details of Expenditure statement of indoor related of D treatment]					
6.	. Indoor related OPD treatment					
	Do you want to claim Indoor related OPD treatment					

### Manual/Offline Reimbursement Claim Form

a	ost i.e cost of OPD treatment 30 days p dmission and 30 days after discharge? (Tick opropriate box)		Yes 🗆			No□
7. De	etails of Indoor related OPD Consultation					
	Dates		No	os. of	Consultation	
8. De	etails of Indoor related OPD treatment Expe	enditure				
SI.	Name of Com	ponents				Amount
No.						Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Inves	tigations				
8.3	Cost of Medicines					
	Period of medicine consumption	From		То		
8.4	Cost of Special Devices	•				
8.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
				Nos.	of Vouchers	

### Part-IV [Medical Advance]

9. Details of Medical Advance, if any						
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount	
where it was drawn	Code		Voucher No.	Voucher Date	(Rs.)	

#### Part-V [Refund of Medical Advance]

10. Details of Refund of Medical Advance, if any						
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount	
where it was drawn	Code		Challan No.	Challan Date	(Rs.)	

Net Claim: [Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus Part-V]				
Rs. ;	In words; Rupees			

### Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

# Manual/Offline Reimbursement Claim Form

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆
2	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes 🗆	No 🗆
3	Money Receipts of both Indoor and OPD treatment sequentially	Yes 🗆	No 🗆
4	Copy of related OPD Prescriptions sequentially (if claimed)	Yes 🗆	No 🗆
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes 🗆	No 🗆
6	Copy of Form-H	Yes 🗆	No 🗆
7	Copy of Form-D4	Yes 🗆	No 🗆
8	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes 🗆	No口
9	<ul> <li>In case of death of Employee, Pensioner and Family Pensioner;</li> <li>a. An, affidavit on stamp paper by claimant</li> <li>b. No objection from other legal heirs on stamp papers</li> <li>c. Copy of death certificate</li> </ul>	Yes □ Yes □ Yes □	No 🗆 No 🗆 No 🗆
10	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes 🗆	No 🗆
11	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant	:
Name in Block Letters	:
Designation/Last Designation	:

# Form –C4

# Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital

### under West Bengal Health Scheme

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

### Part-I[General Information]

1. Det	Details of Employee/Pensioner						
Full Nar	me				HRMS ID	/ PPO No.	
(in Block le	etters)						
Enrollm	ient ID No.					plication ID.	
						at the time of	
					Head of Off	from the end of ice)	
2. Det	tails of Patie	nt, Treating Hos	oital and Con	donation Requ	irement, i	fany	
2.1	Name of Pati	ent					
2.2	Name of Emp	oanelled/Enlisted	hospital				
۱ I I	where treatn	nent was availed					
2.3 F	Requirement	of approval	of delay	Yes 🗆	No 🗆	Not kno	own 🗆
	Condonation,	, ,	mark in				
ā	appropriate b	ox)					
3. Det	tails of Claim	ant (applicable i	n case of dea	th of employee	or pensior	ner or family p	ensioner)
SI. No.		Nan	ne of claiman	it		Re	lation
3.1							
4. Per	rmission Det	ails (If any)					
SI. No.	Per	mission sought		De	etails of pe	rmission appr	oval
4.1	For treatn	nent availed in	empanelled	Permission ID	:		
		spital within Wes	• •	Permission app	proved for:		
		f Order No. 796 ar					
		11253-F(MED), date					
<i>and 7578-F(MED) dated;04.09.2012]</i> 4.2 For treatment availed in enlisted			Memo No.		:		
			Date:		·		
hospital outside West Bengal (see clause 14 of Order No.7287, dated				Authority			
		-	207, 00100				
	19.09.2008	5).		U.O. No. and			
				Finance Deptt. West Bengal, if any:			

### Part-II [Expenditure Statement of IPD treatment]

5. Det	5. Details of Treatment in Reimbursement Mode(If No is selected in Sl. No 3)									
Period o	Period of treatment Admission Date Discharge date									
6. Тур	e of Discharge									
SI. No.	SI. No. Type of Discharge (Tick mark in appropriate box) SI. No. Type of Discharge						(Tick mark in appropriate box)			
6.1	Normal				6.3	Referral				
6.2	Risk Bond				6.4	Death				
7.Amou	nt Claimed for									
Sl. No.	SI. No. Type of Treatment						(Tick mark in appropriate box)			
6.1	6.1 Only Procedural/ Package Treatment									

6.2	Only Non- Procedural/ Non-Packag						
6.3	Both Procedural/ Package and Non- Procedural/ Non-Package						
	Treatment						
7.1 De							
Pe	riod of Procedural/ Package Treatm	nent	From				То
Sl.No.	Name of Procedures/ Pa	ackages		Proce	edure	4	Amount Claimed(Rs.)
				Со	de		
7.1.1							
7.1.2							
7.1.3							
7.1.4							
7.1.5							
					Tota		
	etails of Implants Used						
Sl. No.	Name of Implants	Coded o		Impla		Ar	mount Claimed (Rs.)
		cod	led	Code			
				code	ed		
7.2.1							
7.2.2							
7.2.3							
7.2.4							
7.2.5				Tatal	(Da.)		
7.3 De	tails of Non-Procedural/ Non-Pack	ago Troatm	ant	Total	(KS.)		
	of Non-Procedural/ Non-Package Tr	-	ient.	From			То
Sl. No.		Componen	+	FIUIII			Amount Claimed
51. NO.	Name or	componen	it.				(Rs.)
7.3.1	Room/ Bed Rent						
	ICCU/ITU/ICU/NICU/PICU	From	1	То			
	HDU/SDU	From	1	То			
	Burn Unit	From	1	То			
	CRIB	From	1	То			
	General/Semi-Private/Private	From	1	То			
7.3.2	Consultation Fees.						
7.3.3	Pathological and Radiological Inve	stigations.					
7.3.4	Medicines.						
7.3.5	Consumables						
7.3.6	Special Nursing/Aya Charges						
7.3.7	Miscellaneous. (If any specify)						
	Total Claim of Rein	n <mark>bursemen</mark> (amount r			-	-	
		(amount f	nentione				
	No. of vouchers						

# Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

co a	o you want to claim Indoor related OPD tr ost i.e cost of OPD treatment 30 days dmission and 30 days after discharge? (Tick opropriate box)	prior to	Yes 🗆			No□
9. De	etails of Indoor related OPD Consultation					
	Dates		N	os. of	Consultation	
10. C	Details of Indoor related OPD treatment Ex	penditur	е			
SI.	Name of Com	ponents				Amount
No.						Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Inve	stigation	S			
10.3	Cost of Medicines					
	Period of medicine consumption	From		То		
10.4	Cost of Special Device					
10.5 Miscellaneous (specify)						
Total claim of indoor related OPD(Rs.)						
				Nos.	of vouchers	

### Part-IV [Medical Advance]

12. Details of Medical Advance, if any								
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount			
where it was drawn	Code		Voucher No.	Voucher Date	(Rs.)			

#### Part-V [Refund of Medical Advance]

13. Details of Refund of Medical Advance, if any								
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount			
where it was drawn	Code		Challan No.	Challan Date	(Rs.)			

Net Claim: [Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus V]						
Rs. ;	In words; Rupees					

### Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆
2	Bill Summary of Indoor Treatment and OPD treatment	Yes 🗆	No 🗆
3	Money Receipts of both Indoor and OPD treatment in sequence manner (In chronological order)	Yes 🗆	No 🗆
4	Copy of related OPD Prescriptions (if claimed)	Yes 🗆	No 🗆
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes 🗆	No 🗆
5	Copy of permission granted if any	Yes 🗆	No 🗆
7	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011	Yes 🗆	No□
8	Copy of Detailed Bill of Indoor Treatment	Yes 🗆	No 🗆
9	Original copy of Voucher/ Tax Invoice/Challan of Implants	Yes 🗆	No 🗆
10	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment sequentially	Yes 🗆	No 🗆
11	<ul> <li>In case of death of Employee, Pensioner and Family Pensioner;</li> <li>a. An, affidavit on stamp paper by claimant</li> <li>b. No objection from other legal heirs on stamp papers</li> <li>c. Copy of death certificate</li> </ul>	Yes □ Yes □ Yes □	No 🗆 No 🗆 No 🗆
12	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes□	No 🗆
13	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant	:
Name in Block Letters	:
Designation/Last Designation	:

# Form -C1

### Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

#### Part-I[General Information]

1. D	1. Details of Employee/Pensioner.							
Full Name	9			H	RMS ID / PPO I	No.		
Enrollmer	nt ID No.			Cl	aim Applicatio	n ID.		
Bed Entit	lement			Da	ate of Enrollme	ent		
2. D	etails of Patien	t, Treating Hospital and C	Condonatio	n R	equirement, i	f any.		
2.1	Name of Patier	nt						
-								
	Beneficiary ID							
	Relationship w	ith Employee/Pensioner						
2.2	Name of Empa	nelled/Enlisted hospital w	vhere					
	treatment was	availed.						
-	Code of Hospit	al						
	couc of nospit							
Î	Class of Entitle	ment of Hospital						
-								
	Address of Hos	pital						
2.3	Requirement o	of approval of delay Condo	onation, if		Yes□	No□	Not known 🗆	
	any(Tick mark i	in appropriate box)						
3. D	etail of Claimai	nt (Applicable in case of d	eath of em	ploy	vee or pension	er or family pe	ensioner )	
Sl. No.		Name of claimant				Relati	on	
3.1								
4. P	ermission Deta		1					
Sl. No.	No. Permission sought		D	etai	ils of permissio	on approval		
4.1		nt availed in enlisted	Memo No	Э.		:		
			Date			:		
	-	order no.7287, dated	-	-	Authority	:		
	19.09.2008).		U.O. No. a					
			Finance D	Deptt. West Bengal, if any:				

### Part-II [Details of Expenditure Statement of OPD treatment]

5. I	5. Details of OPD Treatment									
Sl. No.	Particulars	Details								
5.1	Category of OPD Claim (Tick mark in appropriate box) [See list of diseases/illness mentioned in clause 7(1) and 7(2)]			As per clause OPD List	e 7(2) of					
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment									
5.3	Date of OPD consultation									
6. Expenditure Statement of OPD treatment										
SI No.	Name of Components					ınt (Rs.)				

### **Reimbursement Application Form**

6.1	6.1 Consultation Fees				
6.2					
6.3	Cost of Medicines				
	Period of medicine consumption				
6.4	Cost of Special Device				
6.5	Miscellaneous (specify)				
			То	tal	
			No. of vouche	ers	

#### Part-III [Medical Advance]

7. Details of Medical Advance, if any								
Name of Treasury from	DDO	Designation of	Treasury	Treasury	Amount (Rs.)			
where it was drawn	Code	DDO	Voucher No.	Voucher Date				

#### Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any									
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount (Rs.)				
where it was drawn	Code		Challan No.	Challan Date					

Net Claim: [Part-II minus Part III] or [Part-II minus Part-III plus Part IV]			
Rs. ;	In words; Rupees		

### Part-V [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[=				
Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not		
1	Annexure-I duly signed with proper stamp by Treating Specialist of an	Yes 🗆	No 🗆	
	Empanelled/Enlisted Hospital			
2	Money Receipts in sequentially	Yes 🗆	No 🗆	
3	Copy of OPD Prescription	Yes 🗆	No 🗆	
4	Copy of permission granted if any	Yes 🗆	No 🗆	
5	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes 🗆	No 🗆	
6	Copy of all investigation/ test reports in sequentially.	Yes 🗆	No 🗆	
7	In case of death of Employee, Pensioner and Family Pensioner;			
	a. An affidavit on stamp paper by claimant	Yes 🗆	No□	
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No 🗆	
	c. Copy of death certificate	Yes 🗆	No 🗆	
8	Filled ECS mandate form in case of those, whose bank details is not	Yes 🗆	No 🗆	
	available in IFMS (in case of first claim only)			

	Rei	mbursement Appli	cation Form
9	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Clair	mant:
Name in Block Letters	:
Designation/Last Designation	:

# Form –C2

# Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital

### Under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

### Part-I[General Information]

1.	Details of Emplo	oyee/Pensioner.				
Full Na	Name HRM				).	
Enrollment ID Cla		Claim	Claim Application ID			
Bed En	titlement		Date	of Enrollmen	t	
2.	<b>Details of Patien</b>	nt, Treating Hospital and Condo	natior	n Requiremer	nt, if any	
2.1	Name of Patient					
	Beneficiary ID					
	Relationship wit	h Employee/Pensioner				
2.2	Name of Non-En	npanelled/hospital where treatr	nent			
	was availed.					
	Bed Capacity of	Hospital				
	CE Licence No.					
	CE Licence valid	up to				
	Address of Hosp	ital				
2.3	Requirement of	approval of delay Condonation,	if	Yes 🗆	No 🗆	Not known□
	any (Tick mark in appropriate box)					
3.	<b>3.</b> Details of Claimant (Applicable in case of death of employee or pensioner or family pensioner)					
SI. No.		Name of claimant			Rela	tion
3.1						

# Part-II [Details of Expenditure Statement of IPD treatment]

4. Period of treatment					
	Admission Date			Discharge date	
5. T	ype of Discharge				
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box
5.1	Normal		5.3	Referral	
5.2	Risk Bond		5.4	Death	
6. A	mount Claimed for				
Sl. No.		Type of Treatme	ent		Tick markin appropriate box
6.1	Only Procedural/ Packa	ge Treatment			
6.2	Only Non- Procedural/	Package Treatment			
6.3	Both Procedural/ Packa	age and Non- Procedu	ural/ Packa	ge Treatment	
6.1 C	Details of Procedural/ Pa	ickage Treatment			
Р	eriod of Procedural/ Pa	ckage Treatment	From		То
SI. No	Name of Procedures/ Packages			Amount Claimed (Rs.)	
6.1.1					
6.1.2					

6.1.3							
6.1.4							
6.1.5							
					Total		
6.2 I	Details of Implants Used						
Sl. No.	Nam	e of Impla	ants			Amou	unt Claimed
							(Rs.)
6.2.1							
6.2.2							
6.2.3							
6.2.4							
					Total		
	Details of Non-Procedural/ Packag						1
	Period of Non-Procedural/ Packa	-		rom		То	
Sl. No.	Name	of Compo	nents			Αmoι	unt Claimed
							(Rs.)
6.3.1	Room/ Bed Rent			1_	1		
		From		То			
	HDU/SDU	From		То			
	Burn Unit	From		То			
	CRIB	From		То			
	General/Semi-Private/Private	From		То			
6.3.2	Consultation Fees		I		1		
6.3.3	Pathological and Radiological Inv	vestigatior	าร				
6.3.4	Medicines						
6.3.5	Consumables						
6.3.6	Special Nursing/Aya Charges						
6.3.7	Miscellaneous. (If Any Specify)						
					Total		
				No	o. of Vouchers		
		Tota	l Treatmen	t Cost	[6.1+ 6.2+6.3]		

Net Claim:(Part-II)	
Rs. ;	In words; Rupees

### Part-III [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules

# **Online Reimbursement Application Form**

:

:

1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

### [List of Enclosures]

[=:::::			
SI.	Name/Particulars of enclosures to be attached	Enclosed	l or not
No.			
1	Annexure-II duly signed with proper stamp by the Medical		
	Superintendent of a Non-Empanelled Hospital	Yes 🗆	No 🗆
2	Bill Summary	Yes 🗆	No 🗆
3	Money Receipts in sequentially	Yes 🗆	No 🗆
4	Copy of Discharge Summary (Case summary in case of death) and OT		
	note and copy of death certificate	Yes 🗆	No 🗆
5	Detailed Bill	Yes 🗆	No 🗆
6	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes 🗖	No 🗆
7	Copy of all investigation/ test reports in sequentially	Yes 🗆	No 🗆
8	Copy of OT Note in case of procedural/package treatment and		
	treatment summary or bed head ticket in case of non-		_
	procedural/package treatment	Yes 🗖	No 🗆
9	In case of death of Employee, Pensioner and Family Pensioner;		
	a. An affidavit on stamp paper by claimant	Yes 🗆	No□
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No口
	c. Copy of death certificate	Yes 🗆	No□
10	Filled ECS mandate form in case of those, whose bank details is not	Yes 🗆	No 🗆
	available in IFMS (in case of first claim only)		
11	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

#### Signature of the Employee/Pensioner/Claimant:

Name in Block Letters

Designation/Last Designation

### Form –C3

# Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital

#### Under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

Part-I[General Information]

<b>1.</b> De	etails of Employee/Pensioner	
Full Na	ame	HRMS ID / PPO No.
Enrollr	ment ID No.	Claim Application ID.
Bed En	ntitlement	Date of Enrollment
2. D	etails of Patient, Treating Hospital and Condona	ation Requirement, if any
2.1	Name of Patient	
	Beneficiary ID	
	Relationship with Employee/Pensioner	
2.2	Name of Empanelled/Enlisted hospital	
	where treatment was availed.	
	Code of Hospital	
	Class of Entitlement of Hospital	
	Address of Hospital	
2.3	Requirement of approval of delay	Yes 🗌 No 🗌 Not known 🗆
	Condonation, if any (Mark in appropriate	
	box)	
3. D	etails of Claimant (applicable in case of death of a	femployee or pensioner or family pensioner)
Sl.No.	Name of claimant	Relation
3.1		
4. Pe	ermission Details (If any)	
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelle	ed Permission ID :
	private hospital within West Bengal[se	see Permission approved for:
	clause 14 of Order No. 796 and 797, date	
	31.01.2011, 11253-F(MED), dated; 16.12.2011 ar	and
	7578-F(MED) dated;04.09.2012]	

#### Part-II [Expenditure Statement of IPD treatment]

5. Detai	5. Details of Treatment in Cashless Mode							
SI. No.	Particulars			Details				
5.1	Transaction ID of Cashles	ss Treatment						
5.2	Treatment Period	Admission Date		Discharge Date				
5.3	Total Treatment Cost (Rs	5.)						
5.4	Cashless Admissible Reir	nbursement Certificate (	CARC)No.					
7.5	Amount paid to hospital	(Rs.)						
5.6	Amount admissible for re	ARC (Rs.)						
	Total Claim	ment(Rs.)						
	Tota	l nos. of Vouchers/Mone	y Receipts					

#### Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

6.	Indoor related OPD treatment		
	Do you want to claim Indoor related OPD treatment		
	cost i.e cost of OPD treatment 30 days prior to	Yes 🗆	No□
	admission and 30 days after discharge? (Tick mark in		
	appropriate box)		
7.	Details of Indoor related OPD Consultation		

	Dates		N	os. of	Consultation	
8. De	tails of Indoor related OPD treatment Ex	penditure				
SI.	Name of Co	mponents	;			Amount
No.						Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Inv	estigation	S			
8.3	Cost of Medicines					
	Period of medicine consumption	From		То		
8.4	Cost of Special Devices					
8.5	Miscellaneous (specify)					
		Total clain	m of indoor	relate	ed OPD (Rs.)	
				Nos.	of Vouchers	

#### Part-IV [Medical Advance]

9. Details of Medical Advance, if any								
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount			
where it was drawn	Code		Voucher No.	Voucher Date	(Rs.)			

#### Part-V [Refund of Medical Advance]

10. Details of Refund of Medical Advance, if any								
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount			
where it was drawn	Code		Challan No.	Challan Date	(Rs.)			

Net Claim: [Part-II plus Par	rt-III minus Part IV] or [Part-II plus Part-III minus Part IV plus Part-V]
Rs. ;	In words; Rupees

#### Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Sl. No.	Name/Particulars of Enclosures to be attached	Enclosed or not	
1	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes 🗆	No 🗆
2	Money Receipts of both Indoor and OPD treatment sequentially	Yes 🗆	No 🗆

3	Copy of related OPD Prescriptions sequentially (if claimed)	Yes 🗆	No 🗆
4	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes 🗆	No 🗆
5	Copy of Form-H	Yes 🗆	No□
6	Copy of Form-D4	Yes 🗆	No 🗆
7	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes 🗆	No 🗆
8	<ul> <li>In case of death of Employee, Pensioner and Family Pensioner;</li> <li>a. An, affidavit on stamp paper by claimant</li> <li>b. No objection from other legal heirs on stamp papers</li> <li>c. Copy of death certificate</li> </ul>	Yes □ Yes □ Yes □	No □ No □ No □
9	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes 🗆	No 🗆
10	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant	:
Name in Block Letters	:
Designation/Last Designation	:

### Form –C4

# Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital

### Under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

#### Part-I[General Information]

1. D	etails of Emplo	oyee/Pensioner				
Full Na	ame			HRMS	ID / PPO No.	
Enrollr	ment ID No.				Application ID.	
Bed Er	ntitlement			Date o	f Enrollment	
2. D	etails of Patie	nt, Treating Hospita	al and Condona	ation Requirement, if a	ny	
2.1	Name of Pati	ent				
	Beneficiary II	)				
		with Employee/Per				
2.2		panelled/Enlisted ho	ospital			
		nent was availed.				
	Code of Hosp					
		lement of Hospital				
	Address of H	•				
2.3	Requirement	••	•	Yes 🗌 🛛 No	Not knov	wn 🗌
		, if any (Tick	mark in			
appropriate box)						
		,				
	etails of Clai	mant (applicable i		th of employee or pen		
SI. No	etails of Clain	mant (applicable i	<i>n case of deat</i> ne of claimant			pensioner) elation
Sl. No 3.1	etails of Clain	<b>mant</b> ( <i>applicable i</i> Nan				
Sl. No 3.1	etails of Clain	<b>mant</b> ( <i>applicable i</i> Nan				
Sl. No 3.1	etails of Clain	<b>mant</b> ( <i>applicable i</i> Nan		t		elation
Sl. No 3.1 <b>4. P</b>	etails of Clain	mant (applicable i Nan tails (If any)	ne of claimant	t Details o Permission ID	of permission app	elation
Sl. No 3.1 <b>4. P</b> Sl. No	ermission De permission De For treat private ho	mant (applicable i Nan tails (If any) ermission sought ment availed in ospital within We	ne of claimant empanelled est Bengal[see	t Details o Permission ID Permission approved	of permission app	elation
Sl. No 3.1 <b>4. P</b> Sl. No	ermission De ermission De For treat private he clause 14	mant (applicable i Nan tails (If any) ermission sought ment availed in ospital within We of Order No. 796 c	empanelled est Bengal[see and 797, dated	t Details o Permission ID Permission approved	of permission app	elation
Sl. No 3.1 <b>4. P</b> Sl. No	ermission De For treat private he clause 14 31.01.2011,	mant (applicable i Nar tails (If any) ermission sought ment availed in ospital within We of Order No. 796 c . 11253-F(MED), dat	empanelled est Bengal[see and 797, dated red; 16.12.2011	t Details o Permission ID Permission approved	of permission app	elation
SI. No 3.1 <b>4. P</b> SI. No 4.1	ermission De ermission De For treat private he clause 14 31.01.2011, and 7578-F	mant (applicable i Nan etails (If any) ermission sought ment availed in ospital within We of Order No. 796 c , 11253-F(MED), dat (MED) dated;04.09.20	empanelled est Bengal[see and 797, dated red; 16.12.2011 212]	t Details o Permission ID Permission approved	of permission app	elation
Sl. No 3.1 <b>4. P</b> Sl. No	ermission De For treat private ho clause 14 31.01.2011, and 7578-F For trea	mant (applicable i Nan stails (If any) ermission sought ment availed in ospital within We of Order No. 796 o , 11253-F(MED), dat (MED) dated;04.09.20 tment availed	empanelled est Bengal[see and 797, dated red; 16.12.2011 012] in enlisted	t Details o Permission ID Permission approved Memo No.	of permission app	elation
SI. No 3.1 <b>4. P</b> SI. No 4.1	ermission De For treat private he clause 14 31.01.2011, and 7578-F For treat hospital	mant (applicable i Nan tails (If any) ermission sought ment availed in ospital within We of Order No. 796 c , 11253-F(MED), dat (MED) dated;04.09.20 tment availed outside West	empanelled est Bengal[see and 797, dated red; 16.12.2011 012] in enlisted Bengal (see	t Details o Permission ID Permission approved Memo No. Date	of permission app : for: :	elation
SI. No 3.1 <b>4. P</b> SI. No 4.1	ermission De permission De For treat private he clause 14 31.01.2011, and 7578-F For treat hospital clause 14	mant (applicable i Nan Stails (If any) Ermission sought ment availed in ospital within We of Order No. 796 of 11253-F(MED), dat (MED) dated;04.09.20 tment availed outside West 4 of Order No.	empanelled est Bengal[see and 797, dated red; 16.12.2011 012] in enlisted Bengal (see	t Details o Permission ID Permission approved Memo No. Date Designation / Autho	of permission app : for: for:	elation
SI. No 3.1 <b>4. P</b> SI. No 4.1	ermission De For treat private he clause 14 31.01.2011, and 7578-F For treat hospital	mant (applicable i Nan Stails (If any) Ermission sought ment availed in ospital within We of Order No. 796 of 11253-F(MED), dat (MED) dated;04.09.20 tment availed outside West 4 of Order No.	empanelled est Bengal[see and 797, dated red; 16.12.2011 012] in enlisted Bengal (see	t Details o Permission ID Permission approved Memo No. Date	of permission app : for: for: i c for: i c f	elation

### Part-II [Details of Expenditure Statement of IPD treatment]

5. Det	5. Details of Treatment in Reimbursement Mode (If No is selected in SI. No 3)									
Period of treatmentAdmission DateDischarge date										
6. Тур	6. Type of Discharge									
Sl. No.	Type of Disc	charge	(Tick ma appropriat		SI. No.	Type of Discharge	(Tick mark in appropriate box)			
6.1	Norma	al			6.3	Referral				
6.2	Risk Bon	nd			6.4	Death				
7. Am	7. Amount Claimed for									
SI. No.	D. Type of Treatment						(Tick mark in			
	appropriate bo									
7.1	Only Procedura	al/ Packag	e Treatmen	t						

7.2	Only Non- Procedural/ Non-Package Treatment						
7.3	Both Procedural/ Package and Non- Procedural/ Non-Package						
	Treatment						
7.1 De							
	eriod of Procedural/ Package Treatment From					То	
SI. No.	Name of Procedures/ Packages					4	Amount Claimed(Rs.)
				Co	de	_	
7.1.1						_	
7.1.2						_	
7.1.3						_	
7.1.4						+	
7.1.5					Tota		
7.2 D	etails of Implants Used				TOLA	<u> </u>	
SI. No.	Name of Implants	Coded o	nr Non-	Impla	nts	Δr	nount Claimed (Rs.)
51. 10.		cod		Code		7.1	noune claimed (h5.)
				code			
7.2.1							
7.2.2							
7.2.3							
7.2.4							
7.2.5							
	Total (Rs.)						
	tails of Non-Procedural/ Non-Pack			[			
	riod of Non-Procedural/ Non-Packa	-		From			То
Sl. No.	Name of 0	Componen	ts				Amount Claimed (Rs.)
7.3.1	Room/ Bed Rent						
	ICCU/ITU/ICU/NICU/PICU	From	1	То			
	HDU/SDU	From	1	То			
	Burn Unit	From		То			
		11011					
	CRIB	From	1	То			
	General/Semi-Private/Private	From	1	То			
7.3.2	Consultation Fees.						
7.3.3	Pathological and Radiological Invest	stigations.					
7.3.4	Medicines.						
7.3.5	Consumables						
7.3.6	Special Nursing/Aya Charges						
7.3.7	Miscellaneous. (If any specify)						
	Total Claim of Rein	nbursemen (amount r			-	-	
No. of vouchers							

# Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

### **Online Reimbursement Claim Form**

co: ad	you want to claim Indoor related OPD trest i.e cost of OPD treatment 30 days mission and 30 days after discharge? (Tick propriate box)	prior to	Yes 🗆			No□
9. Det	ails of Indoor related OPD Consultation					
	Dates		Ν	os. of	Consultation	
10. D	etails of Indoor related OPD treatment Ex	penditur	e			
Sl. No.	Name of Cor	nponents	5			Amount
						Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Invo	estigatior	าร			
10.3	Cost of Medicines					
	Period of medicine consumption	From		То		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	Т	otal clair	n of indoor	relate	ed OPD (Rs.)	
				Nos.	of vouchers	

### Part-IV [Medical Advance]

11. Details of Medical Advance, if any								
DDO	Designation of DDO	Treasury	Treasury	Amount				
Code		Voucher No.	Voucher Date	(Rs.)				
	DDO	DDO Designation of DDO	DDO Designation of DDO Treasury	DDO Designation of DDO Treasury Treasury				

#### Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any							
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount		
where it was drawn	Code		Challan No.	Challan Date	(Rs.)		

Net Claim: [Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus V]						
Rs. ;	In words; Rupees					

### Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

## **Online Reimbursement Claim Form**

:

:

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes 🗆	No 🗆
2	Money Receipts of both Indoor and OPD treatment sequentially	Yes 🗆	No 🗆
3	Copy of related OPD Prescriptions sequentially (if claimed)	Yes 🗆	No 🗆
4	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes 🗆	No 🗆
5	Copy of permission granted if any.	Yes 🗆	No 🗆
6	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011	Yes 🗆	No口
7	Copy of Detailed Bill of Indoor Treatment	Yes 🗆	No 🗆
8	Original copy of Voucher/ Tax Invoice/Challan of Implants	Yes 🗆	No 🗆
9	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment in sequence manner (In chronological order)	Yes 🗆	No 🗆
10	<ul> <li>In case of death of Employee, Pensioner and Family Pensioner;</li> <li>a. An affidavit on stamp paper by claimant</li> <li>b. No objection from other legal heirs on stamp papers</li> <li>c. Copy of death certificate</li> </ul>	Yes □ Yes □ Yes □	No □ No □ No □
11	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes 🗆	No 🗆
12	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

# Signature of the Employee/Pensioner/Claimant: Name in Block Letters Designation/Last Designation

# Annexure-I

### Certification of Treating Specialist of <u>Empanelled Hospital</u> for claiming reimbursement of <u>"Out Patient</u>" <u>Department"</u> treatment under WBHS

1.	Certified that the patient, Sri/Smt	is a beneficiary of West
	Bengal Health Scheme having the Beneficiary ID is	

2. S/he has been suffering from \_\_\_\_\_\_\_ (specify name of disease) as listed in SI. No.\_\_\_\_\_\_\_ of the OPD list as per 7(1) clause or follow-up medical attendance and treatment of \_\_\_\_\_\_\_ as per 7(2) clause of order number 7287-F, dated 19/09/2008 issued by Medical Cell, Finance Department, Government of West Bengal.

#### Date:

Signature of the Treating Specialist
Registration No:
Registering Authority:
Present Degree:
Hospital

### **Official Seal of Treating Hospital**

### List of OPD (Out-Patient Department) Diseases

As per clause 7(1) of 7287-			s per clause 7(1) of 7287–F, dated; 19-09-2008		
SI. No	Name of Disease	SI. No	Name of Disease	SI. No	Name of Disease
1	Malignant Diseases.	10	Injuries Caused by Accident (including Animal Bite).	1	Neuro Surgery.
2	Tuberculosis.	11	Rheumatoid Arthritis.	2	Cardiac Surgery (Including Coronary Angioplasty and implants).
3	Hepatitis B/C and Other Liver Diseases.	12	Systematic Lupus Erytthematous (LUPUS).	3	Cancer Surgery/ Chemotherapy/ Radiotherapy.
4	Insulin Dependent Diabetes (Type-2 Diabetic Mellitus is not considered as Insulin Dependent Diabetes).	13	Crohn's Disease.	4	Renal Transplant.
5	Heart Diseases.	14	Endodontic Treatment (Root Canal Treatment).	5	Hip/ Knee replacement Surgery.
6	Neurological Disorder/ Cerebra vascular Disorders.	15	COPD (Chronic Obstructive Pulmonary Disease).	6	Accident cases.
7	Malignant Malaria.	16	Ankylosing Spondylitis		
8	Renal Failure.	17	None of the above list [ Vide para 10 of 797-F(MED), dated 31.01.2011]		
9	Thallasaemia/ Bleeding orders/ Platelet Disorders.				

# Annexure-II

Certification of Medical Superintendent/ Administrative Officer and Treating Specialist of treating in **Non-Empanelled Hospital** for claiming reimbursement of only <u>"Indoor"</u> treatment under WBHS

1.	Certified that the patient, Sri/Smt	is	а
	beneficiary of West Bengal Health Scheme having the Beneficiary		ID
	is availed indoor treatment from to	_•	
2.	Certified that the Hospital/Nursing Home/Health Care Organisation has (		)
	nos. of bed.		
3.	Certified that the Hospital/Nursing Home/Health Care Organisation obtained a License und	er t	the
	West Bengal Clinical Establishment Act and Rules bearing no and this Lice	ns€	e is

valid up to \_\_\_\_\_.

Date:

Signature of Medical Superintendent ..... Hospital Official Seal of the Hospital