

Medical Reimbursement cases

Medical Reimbursement forms - [Download](#)

MEDICAL REIMBURSEMENT CLAIMS

CHECK LIST

Before the claim file is received from the claimant, he /she should be advised the following

S.N	Details of enclosures
1.	To submit the claim in triplicate with its enclosures filed in the sequence mentioned in the list. To provide the contact number that is in use (mobile and Land line) and the Railway phone number in case of serving employees.
2.	A hand written or typed bill summary- with the details of bill No., Date and the amount should be insisted with signature of the claimant.
3.	After the filing all the documents in the sequence, all the folios should be clearly numbered with a sketch pen.
4.	They should ensure that all the bills – medicine bills, investigation bills etc. pertain only to the inpatient period for which reimbursement can be considered.
5.	He/she shall be responsible to advise any change of address to the concerned in writing.
6.	If the claimant is retired employee, he should submit the GP-46 form(Letter of Authority for payment giving complete details of the Bank account number and the Bank address duly affixing a revenue stamp.

CLAIM FILE FROM TOP TO BOTTOM ORDER OF ENCLOSURES

S.N	Details of enclosures	Yes/ No	N. A.	P.No .
1.	PROPOSAL LETTER OR THE REQUEST LETTER WITH COMPLETE ADDRESS(OFFICE AND RESIDENTIAL IN CASE OF SERVING EMPLOYEE AND THE CONTACT NUMBERS BOTH MOBILE AND LANDLINE)			
2.	RELHS WITH REGN.NO. /THE SERVING EMPLOYEE'S MEDICAL CARD DULY ATTESTED.			
3.	GR-3 FORM AND ITS ANNEXURES.			
4.	CONSOLIDATED HOSPITAL BILL WITH CLEAR BREAK UP OF CHARGES.			
5.	BILL SUMMARY.			
6.	ALL ORIGINAL BILLS PERTAINING TO MEDICINES PURCHASED TO THE PERIOD OF HOSPITALISATION PERIOD.			
7.	DISCHARGE SUMMARY/DEATH SUMMARY.			
8.	AFFIDAVIT WHERE CLAIMANT IS LEGAL HEIR.			
9.	ALL INVESTIGATION REPORTS, SCAN REPORTS.			

GENERAL CHECK LIST

S.No.	Items to be check	Yes/ No	N. A.	P.No .
1.	A Check list and file movement slip should be pasted on the original copy of the claim file			
2.	Every claim File should be neatly segregated as original, duplicate and triplicate copy.			
3.	Contact number is mentioned on the file			
4.	In-time or belated claim			
5.	If the proposal is forwarded by controlling officer			
6.	Attested copy of the Medical card enclosed			
7.	If the claimant is a retired employee, the copy of RELHS card should be checked for registration number and if the patient's name is available in the family composition			
8.	Whether the claimant's request letter is dated properly and is forwarded by the controlling officer.			
9.	Whether the GR-3 form is filled in completely with break up of expenditure under			

	different heads is filled in.			
10.	Annexure III Part A,B and C are duly signed and Doctor's seal and Hospital seal is affixed			
11.	Discharge summary of the hospital signed by the treating doctor			
12.	Whether all the bills are signed by the treating doctor or by an authorized medical officer of the concerned hospital.			
13.	Whether the patient has expired, if the Death summary is enclosed.			
14.	When the claim is submitted by the legal heir, an affidavit on a stamp paper is enclosed where all the legal heirs sign on the affidavit saying that the claimant can be paid the entire amount that is reimbursable as medical reimbursement and they have no objection for the same.			
15.	All the investigation reports are enclosed.			
16.	Scan reports are enclosed.			
17.	Where the doctor's name seal not affixed and the bills are signed by a authorized medical officer of the hospital, a certificate from the hospital to the effect the signatory is empowered to sign on behalf of the treating doctor.			
18.	If the summary of bills is submitted duly tallying with the amount claimed.			
19.	In case of a road accident case, an undertaking from the claimant to the effect that he has/has not claimed Rs.-----/-ny amount from any insurance company.			
20.	GP-46 with the bank account no., address of the bank & signature of the claimant over the revenue stamp is available,in case the claimant is a retired employee/dependent of the deceased employee.			
21.	Patient is implanted with a stunt, - the original voucher is submitted. Where the stunt is provided by the concerned hospital through their stores and is included in the consolidated hospital bill, a certificate from the hospital authority stating that the stunt is procured in bulk and that it is provided to the patient at a cost of Rs.-----which is inclusive of a tax element of Rs.----- . This should be invariably signed by the treating doctor only. The details of the type make and date of purchase of the consignment should be mentioned in the certificate.			
22.	Bonafide certificate when the patient is scholar son.When the son is over 21 years and not a scholar a declaration from claimant stating that tha son is dependent and not earning.			
23.	After verifying the claim ,AMO will verify for emergency as per Railway Board letter even no,dt.31.01.07 and obtain approval ofCMS/MD. Admissibility will be worked out if the claim is recommended.If the amount is less than Rs.10,000/-it should be dealt at Divisional nlevel and if the amount exceeds,more than Rs.10,000/-the claim should be forwarded to CMD/O/SC with associate finance concurrence.			

MEDICAL REIMBURSEMENT CLAIMS

CHECK LIST FOR THE CLAIMS SUBMITTED BY SERVING EMPLOYEE

S.N	Items to be check	Yes/ No	N. A.	P. No.
1.	A Check list and file movement slip should be pasted on the original copy of the claim file			
2.	Every claim File should be neatly segregated as original, duplicate and triplicate copy.			

3.	Contact number is mentioned on the file			
4.	In-time or belated claim			
5.	If the proposal is forwarded by controlling officer			
6.	Attested copy of the Medical card enclosed			
8.	Whether the claimant's request letter is dated properly and is forwarded by the controlling officer.			
9.	Whether the GR-3 form is filled in completely with breakup of expenditure under different heads is filled in.			
10.	Annexure III Part A,B and C are duly signed and Doctor's seal and Hospital seal is affixed			
11.	Discharge summary of the hospital signed by the treating doctor			
12.	Whether all the bills are signed by the treating doctor or by an authorized medical officer of the concerned hospital.			
13.	Whether the patient has expired, if the Death summary is enclosed.			
14.	All the investigation reports are enclosed.			
15.	Scan reports are enclosed.			
16.	Where the doctor's name seal not affixed and the bills are signed by a authorized medical officer of the hospital, a certificate from the hospital to the effect the signatory is empowered to sign on behalf of the treating doctor.			
17.	If the summary of bills is submitted duly tallying with the amount claimed.			
18.	In case of a road accident case, an undertaking from the claimant to the effect that he has/has not claimed Rs.-----/-any amount from any insurance company.			
19.	Patient is implanted with a stunt,- the original voucher is submitted. Where the stunt is provided by the concerned hospital through their stores and is included in the consolidated hospital bill, a certificate from the hospital authority stating that the stunt is procured in bulk and that it is provided to the patient at a cost of Rs.-----which is inclusive of a tax element of Rs.-----. This should be invariably signed by the treating doctor only. The details of the type make and date of purchase of the consignment should be mentioned in the certificate.			
20.	After verifying the claim ,AMO will verify for emergency as per Railway Board letter even no,dt.31.01.07 and obtain approval ofCMS/MD. Admissibility will be worked out if the claim is recommended.If the amount is less than Rs.10,000/-it should be dealt at Divisional nlevel and if the amount exceeds,more than Rs.10,000/-the claim should be forwarded to CMD/O/SC with associate finance concurrence.			

ESSENTIALITY CERTIFICATE

This should be filled by the treating doctor in the format given below on the letter head of the Hospital.

**CHECK LIST FOR REIMBURSEMENT CLAIMS TO BE FULFILLED BY THE
EMPLOYEE/ CLAIMANT**

- 1) Application from the employee/claimant addressed to CMS/MD as applicable.
- 2) Reimbursement claim consisting of application of the employee, discharge/death summary, bills, Annexure III, IV, V & VI, Medical Identity/RELHS card, legal affidavit if applicant expired, Bonafide Certificate from school/college duly attested by the Gazetted Officer in case the patient is dependant son aged above 21 years to be submitted in 4 copies.
- 3) Total amount claimed has to be rightly mentioned in the appropriate columns in the different heads of expenditure.
- 4) Annexure-III-Certificate-A form for investigation only (for non-admitted cases)
- 5) Annexure-III-Certificate-B for admitted cases only.
- 6) All forms where ever signature of the Medical Officer is mentioned are to be signed by the Treating Doctor along with his name stamp without which no claim will be entertained.
- 7) Original bills should be verified by the Treating Doctor without which no claim will be entertained.
- 8) Proforma (Annexure VI) column 1 to 20 to be filled in by the applicant if the claim amount is above Rs. 2 Lakhs.
- 9) Cash Memo in support of all claims including purchase of pacemaker, hearing aid and prothesis duly countersigned by the doctor to be enclosed.
- 10) Reimbursement claim should be submitted within 6 months from the date of treatment

(See Para 645,653 of IRMM)

**CERTIFICATE TO BE OBTAINED FOR ATTENDING NON-RAILWAY INSTITUTION FOR
CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES**

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 duty
 5. Actual residential address
 -
 6. Name of the patient and his/her relation to the Railway employee
- Note: In the case of children, state age also.
7. Place at which the patient fell ill
 8. Nature of illness and its duration

(a) that the injections administered were not for immunising 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 at
(name of hospital or laboratory).

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

(g) that the patient did not require hospitalization.

Signature and designation of the
Medical Officer

Date.....

Name of the hospital/dispensary
to which attached

Place

Note: Certificates not applicable should be struck off. Essentiality certificate as given in 8 (b) as above is
compulsory and must be filled in by the Medical Officer in all cases.

CERTIFICATE 'B'(To be completed in the case of patients who are admitted to hospital for treatment)**Part A**

I, Dr..... hereby certify:
 (a) that the patient was admitted to hospital on my advice/on the advice of
(name Of Medical Officer).

(b) that the patient has been under treatment at 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 the hospital)..... for supply to private patients and do not include proprietary preparations 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. ....	.....

(c) that the injections administered were not for immunising or prophylactic purposes.

(d) that the patient was suffering from and was under my treatment from to.....

(e) that the X-ray, laboratory tests, etc. for which an expenditure of Rs..... was incurred were necessary and were undertaken on my advice at
 (name of hospital or laboratory).

(f) that I called in Dr..... for specialist consultation and that the necessary approval of the..... (name of the principal Medical Officer), as required under the rules was obtained.

Date

Place

.....
 Signature and designation of the
 Medical Officer in charge of the case at the hospital

Part B

I certify that the patients has been under treatment at the hospital and that the services of the special nurses, for which an expenditure of Rs..... was incurred vide bills and receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Date.....

Place

.....
 Signature and designation of the
 Medical Officer in charge of at the hospital.

Countersigned

.....
 Principal Medical Officer

Part C

I certify that Shri/Shrimati/Kumari..... wife/
son/ daughter of..... employed in
the has been under treatment
for Disease from
to..... at the..... Hospital and that the facilities
provided were the minimum which were essential for the patient’s treatment.

Date.....
.....

Place Medical Department
.....Hospital

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

(See Para 653 of IRMM)

**FORM OF APPLICATION TO BE SUBMITTED BY A RAILWAY EMPLOYEE FOR
CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES**

(Note: Separate form should be used for each patient)

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 duty
 5. Actual residential address
.....
 6. Name of the patient and his/her relationship to the Railway employee
.....
- Note: In the case of children, state age also.
7. Place at which the patient fell ill
.....
 8. Nature of illness and its duration.....
 9. Details of the amount claimed
- I. Medical Attendance:
- (i) Fees for consultation indicating
 - (a) the name and designation of the Medical Officer consulted and
.....the hospital or dispensary to which attached.
 - (b) the number and dates of consultations and the fees paid for each consultation
.....
 - (c) the number and dates of injections and the fee paid for each
..... injection.
 - (d) whether consultations and/or injections were had at the hospital,
.....at the consulting room of the Medical Officer or at the
residence of the patient.
 - (ii) Charges for pathological, bacteriological, radiological or other
.....
similar tests undertaken during diagnosis, indicating:
 - (a) The name of the hospital or laboratory where the tests were undertaken.....
.....
 - (b) Whether the tests were undertaken on the advice of the
..... Authorised Medical Officer. If so, a certificate to
that effect should be attached.
 - (c) Cost of medicines purchased from the market (List of
.....medicines, cash memo and the
essentiality certificates should be attached).

II. Hospital Treatment:

Charges or hospital treatment, indicating separately the charges for:

(i) Accommodation

.....

.....
(State whether it was according to the status or pay of the Railway employee and in cases where the accommodation is higher than the status of the Railway employee, a certificate should be attached

to the effect that the accommodation to which he was entitled was not available).

(ii) Diet

(iii) Surgical operation or medical treatment

(iv) Pathological, bacteriological, radiological or other similar tests indicating:

(a) the name of the hospital or laboratory at which undertaken

(b) and whether undertaken on the advice of the Medical Officer,
in charge of the case at the hospital. If so, a certificate to that effect should be attached.

(v) Medicines

(vi) Special medicines

(List of medicines, cash memo and the essentiality certificate should be attached).

(vii) Ordinary nursing.

(viii) Special nursing i.e., nurses special engaged for the patient

(State whether they were employed on the advice of the Medical Officer in charge of the case at the hospital or at the request of the Railway employee or patient. In the former case, a certificate from the Medical Officer in charge of the case and countersigned by the Medical Superintendent of the hospital should be attached).

(ix) Ambulance charges

(State the journey – to and from – undertaken)

(x) Any other charges e.g., charges for electric light, fan, heater, ..., air-conditioning, etc.

(State also whether the facilities referred to are a part of the facilities normally provided to all patients and no choice was left to the patient).

Note: (1) If the treatment was received by the Railway employee at his residence under Para 634, give particulars of such treatment and attach a certificate from the Authorised Medical Officer as required.

(2) If the treatment was received at a hospital other than a Government, recognised hospital, necessary details and the certificate of the Authorised Medical Officer that the requisite treatment was not available in any nearest Government/recognized hospital should be furnished.

III. Consultation with a specialist:

Fees paid to a specialist or a Medical Officer other than the Authorised Medical Officer, indicating:

(a) the name and designation of the specialist Medical Officer,
consulted and the hospital to which attached.

(b) number and dates of consultations and the fee charged for,
each consultation.

(c) whether consultation was had at the hospital, at the consulting,
room of the specialist or Medical Officer, or at the residence of the patient.

(d) whether the specialist or Medical Officer was consulted on the

advice of the Authorised Medical Officer and the prior approval of the Chief Medical Director of the Railway was obtained. If so, a certificate to that effect should be attached.

10. Total amount claimed

11. List of enclosures

.....
.....

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.

Date.....

Place

SIGNATURE OF THE RAILWAY EMPLOYEE.

(See Para 659)

**..... RAILWAY
MEDICAL DEPARTMENT
ESSENTIALITY CERTIFICATE**

I certify that Shri/Shrimati/Kumar
 wife/son/daughter of employed in
 the has been under my treatment for
 disease from
 to at
 the hospital/my consulting room 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 hospital
 and do not include proprietary preparations for which
 hospital for supply to private patients cheaper substances of equal therapeutic value are available,
 nor preparations, which are primarily foods, toilers or disinfectants.

Name of medicines**Price**

1. ....	.....
2. ....	.....
3. ....	.....
4. ....	.....
5. ....	.....

.....
 Signature of the Medical Officer
 In charge of the case at the hospital.

Date

Place

.....
 Signature and designation of the
 Authorized Medical Officer

(See Para 648)

**Proforma for submission of claim for reimbursement of medical expenses incurred by
Railway Employees for treatment in Private Hospital/Non-Recognised 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, if delayed for more than 3 months	
11	Total period of stay as Indoor patient	
12	Reasons for long stay (if stayed for more than 48 Hrs)	
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 ad if YES when.....)	
20	Total amount claimed (with break-up charges)	
21	Item wise break of expenditure had the treatment taken place in Govt. Hospital.	
22	Verbatim views of C.M.D	
23	Verbatim views of F.A & C.A.O	

प्रतिपूर्ति दावा फार्म के लिये चैक लिस्ट
CHECK LIST FOR REIMBURSEMENT CASES

1. चिकित्सा/आर.ई.एल.एच.एस./पहचान-पत्र की राजपत्रित अधिकारी द्वारा सत्यापित प्रतिलिपि।
 Medical card/RELHS medical card photocopy duly attested by gazetted officer.
2. (A) रेफर्ड स्लिप
 Referred Slip
 (B) जिन केसों को रेफर नहीं किया गया हो, कर्मचारी/सेवानिवृत्त कर्मचारी का प्रार्थना-पत्र जिसमें मरीज को अस्पताल में भर्ती करने के समय मरीज की हालत/उन हालातों का उल्लेख करें जिसके कारण नान-रेलवे अस्पताल में इलाज करवाया गया है।
 For non-referred cases Application of employee describing the condition of the patient and circumstances for going directly to non-railway hospital.
3. डिस्चार्ज स्लिप का मूल प्रमाण-पत्र/पर्ची
 Discharge slip in original
4. बिल/वाउचर की मूल प्रतियां
 इलाज करने वाले डाक्टर द्वारा हस्ताक्षरित/प्राधिकृत चिकित्सा अधिकारी द्वारा हस्ताक्षरित
 Bill/Vouchers (In original)
 (Duly countersigned by treating Doctor)
5. सभी बिलों की समरी क्रम व तारीखनुसार जैसा कि प्रतिपूर्ति दावा फार्म के फुटनोट 2 (f) में दर्शाया गया है जो इलाज करने वाले डाक्टर द्वारा हस्ताक्षरित/प्राधिकृत चिकित्सा अधिकारी द्वारा हस्ताक्षरित।
 Summary of bills in serial number/date wise as given in reimbursement claim form, foot note 2 (f) (duly countersigned by treating Doctor and countersigned by AMO).
6. इलाज करने वाले अस्पताल के डाक्टर द्वारा जारी आवश्यकता प्रमाण-पत्र जो कि अस्पताल के चिकित्सा अधीक्षक या इन्चार्ज द्वारा प्रतिहस्ताक्षरित।
 Essential certificate (signed by treating Doctor and countersigned by Medical Supdt./incharge of the hospital).
7. चिकित्सा प्रतिपूर्ति फार्म कर्मचारी एवं नियंत्रण अधिकारी/यूनिट प्रभारी द्वारा प्रति हस्ताक्षरित।
 Medical reimbursement form duly signed by employee and controlling officer.

चैक किया एवं सही पाया
 Checked and found O.K.

.....
 चिकित्सा विभाग के व्यावहारिक लिपिक के हस्ताक्षर
 Sign. of Dealing Clerk of Medical Deptt.

पंजीकरण संख्या.....

Regn. No.

दिनांक.....

Date

नोट :- उपरोक्त अनुलग्नकों के बिना फार्म स्वीकार नहीं किये जायेंगे।

Note :- Without above enclosures form will not be accepted

उत्तर रेलवे
NORTHERN RAILWAY

अनुबन्ध 'क' पत्र संख्या नं. 494-ई/O VII/ई IV, दिनांक 29-2-99/31-3-99

Annexure 'A' to letter No. 494-E/O VII/E IV, dated 29-2-99/31-3-99

चिकित्सा प्रतिपूर्ति-फार्म
MEDICAL REIMBURSEMENT FORM

1. कर्मचारी/भूतपूर्व कर्मचारी का नाम
Name of Employee/Ex. Employee
2. कर्मचारी सेवारत/सेवानिवृत्त हैं
Whether serving or retired
3. पदनाम
Designation
4. किस कार्यालय/यूनिट में तैनात है
Office/Unit of posting
5. कर्मचारी का वेतन दर एवं वेतनमान अगर कर्मचारी सेवा-निवृत्त है तो उसकी अंतिम वेतन दर :-
Pay & Scale of Employee/Pay last drawn in case of ex-employee.
6. रोगी का नाम
Name of Patient
- जिस रोगी के लिए प्रतिपूर्ति का दावा किया गया है उसका रेल कर्मचारी से सम्बन्ध।
Relationship with railway employee for whom reimbursement is claimed.
7. रोगी की आयु
Age of Patient
8. चिकित्सा/सेवा-निवृत्त कर्म० उदा० स्था० योजना पहचान-पत्र सं.
Medical/RELHS I/Card No.
9. रोगी को रेफर किया गया अथवा नहीं
Whether referred or non referred
1. अगर रोगी को रेफर किया गया/अथवा नहीं
If referred by whom ?
2. जिस अस्पताल में उपचार किया गया उसका नाम
Name of the institution where treatment is taken
3. अस्पताल में भर्ती होने की तारीख
Date of admission
4. अस्पताल से छुटी मिलने की तारीख
Date of discharge
5. प्रतिपूर्ति के लिए दावा करने की तारीख

16. यदि प्रतिपूर्ति के लिए दिया गया दावा छः माह से अधिक विलम्ब से
 किया गया हो तो देर से दावा प्रस्तुत करने का कारण।
 Reasons for delayed, submission of claim, it delayed for more than 6 months.
17. अन्तरंग रोगी के रूप में भर्ती रहने की कुल अवधि
 Total period of stay as indoor patient
- 18.* अधिक समय तक भर्ती रहने का कारण—यदि 48 घंटों से अधिक समय
 तक भर्ती रहा हो।
 Reasons for long stay (if stayed for more than 48 hrs.)
- 19.* आपातकालीन चिकित्सा का विवरण
 Type of medical emergency
- 20.* क्या उपचार के लिए रेलवे-सरकारी सुविधा उपलब्ध नहीं थी ?
 Was there no Railway/Govt./facility available to deal it ?
- 21.* निवास स्थान से निकटतम सरकारी अस्पताल की दूरी एवं क्या वहां
 उपचार की सुविधा उपलब्ध है।
 Distance of the nearest Govt. Hospital & whether facilities available there.
- 22.* निवास स्थान से निकटतम रेलवे अस्पताल की दूरी एवं वहां उपलब्ध
 उपचार की सुविधा रेलवे अस्पताल नहीं है तो निवास स्थान से कितनी दूर है।
 Distance of the nearest Rly. Hospital & whether facilities available there. If not, how far is the Railway Hospital with the facilities available.
- 23.* निवास स्थान बीमारी स्थान से प्राईवेट अस्पताल की सुविधा हैं तो
 उसकी दूरी।
 Distance of the Private Hospital from residence/Place of illness, where facilities availed.
- 24.* अस्पताल में भर्ती होने की सूचना रेल चिकित्सा अधिकारी को कब दी
 गई ?
 When the Railway Medical Officer was informed about such admission ?
- 25.* क्या रोगी इस बीमारी से पहले या बाद में किसी प्रकार का उपचार
 लिया यदि इससे पूर्व उपचार लिया हो यदि हां, तो कब ?
 Did the patient take any treatment before or after for the present sickness (if this existed before). and if yes, when ?
- 26.* प्रतिपूर्ति के लिए किए गए दावों की कुल राशि खरीदी गई दवाओं के
 अलग-अलग खर्चों सहित नीचे दिए गए फुट नोट की मद सं. (च) की विस्तृत हिदायतों अनुसार।
 Total amount claimed (with break-up of charges) (detailed instructions at (f) of foot note below).
- 27.* अनुलग्नकों की कुल संख्या
 Total number of enclosures.

28.* कर्मचारी के घर का पता
Employee's residential address

29.* बीमार पड़ने का स्थान व पता
Place/Address of falling sick

30.* फोन नं.
Phone No.

नियंत्रण अधिकारी यूनिट प्रभारी के प्रति हस्ताक्षर
केवल सेवारत कर्मचारियों के मामले में
Counter sign of Controlling Officer/Unit Incharge
(in case of serving employees only)

कर्मचारी/सेवा निवृत्त कर्मचारी
पति/पत्नी के हस्ताक्षर
Signature of Employee/
Ex-Employees/Spouse

चिकित्सा प्रतिपूर्ति के लिए दावा करने वाले कर्मचारी चिकित्सा प्रतिपूर्ति के घोषणा पत्र पर हस्ताक्षर करें।

Declaration to be signed by the person claiming Medical Reimbursement :-

मैं, एतद् द्वारा घोषणा करता/करती हूँ की इस आवेदन में दी गई घोषणाएं मेरी जानकारी एवं विश्वास के अनुसार सत्य हैं और
I hereby declare that the statement in this application are true to the best of my knowledge and belief and

- (i) कि जिस व्यक्ति के लिए चिकित्सा व्यय किया गया था, वह मुझ पर पूर्ण रूप से आश्रित है।
That the person for whom medical expenses were incurred is wholly dependent upon me.
- (ii) चिकित्सा व्यय स्वयं पर किया गया।
The medical expenses were incurred for self.

उपर्युक्त i एवं ii में से जो लागू न हो उसे काट दिया जाए।
(Strike-out what is not applicable from (i) & (ii) above)

दिनांक :
Date :

स्थान :
Place :

रेल कर्मचारी के हस्ताक्षर
Signature of Rly. Servant/

पदनाम एवं कार्यालय
Designation and office to
which attached

फुट नोट/Foot-note

1. मद सं. 18, 19, 20, 21, 22, 23, 24 एवं 25 केवल उन्हीं मामलों पर लागू होती है जिन्हें रेफर नहीं किया गया हो।

Item No. 18, 19, 20, 21, 22, 23, 24 & 25 are applicable only for non-referred cases.

2. इस प्रोफार्मा के साथ निम्नलिखित दस्तावेज संलग्न किए जाएं :-

Following documents should be attached with this proforma :-

- (i) कर्मचारी/सेवानिवृत्त कर्मचारी उन परिस्थितियों का उल्लेख करते हुए आवेदन करें जिनके तहत इलाज करवाया हो।
Employees/Retired Employees Application giving circumstances under which he/she took treatment.
- (ii) चिकित्सा/आर.ई.एल.एच.एस. पहचान-पत्र की राजपत्रित अधिकारी द्वारा विधिवत् प्रमाणित हो-फोटो प्रति।
Photo copy of Medical/RELHS I.D. Card (duly attested by a Gazetted Officer)
- (iii) उपचार करने वाले अधिकारी द्वारा जारी मूल चिकित्सा प्रमाण जिसे अस्पताल के चिकित्सा निदेशक द्वारा प्रतिहस्ताक्षर किया गया हो।
Essentiality certificate issued by the treating doctor of hospital countersigned by Medical Supdt. of the treating hospital.
- (iv) अस्पताल छोड़ने का मूल प्रमाण-पत्र/पर्ची।
Discharge certificate/slip in original.
- (v) उपचार करने वाले अधिकारी द्वारा विधिवत् प्रति हस्ताक्षरित बिल/वाउचर्स।
Bills/Vouchers (in original) duly countersigned by treating officer (Authorised M.O.)

- (vi) सभी बिलों का फुटकर विवरण—इसका तात्पर्य होगा कि उपर्युक्त मद (ड) प्रस्तुत किए गए सभी बिल/वाउचर उचित ढंग से प्रस्तुत किए गए हैं। उदाहरण के लिए :-
Detailed item-wise break-up of all the bills (this means all bills/vouchers submitted at (v) above should be reproduced in Legible Manner) for e.g. :-

बिल सं. Bill No.	दवा विक्रेता-दुकान का नाम Name of Chemist/Shop	दिनांक Date
मदों का विवरण Description of item	मात्रा Qty.	कीमत Price
		रुपये/Rs. पै./P.
1.		
2.		
3.		
4.		
कुल जोड़/Total		

- (vii) रेफर किए गए मामलों में, रेफर स्लिप की मूल प्रति संलग्न करें।
In case of referred cases, attach original referred slip.

- (viii) केस प्रस्तुत करने के लिए हिदायतें :-

Instruction for submission :-

रेफर किए गए मामलों में आवेदन को नियंत्रण अधिकारी/अधीनस्थ प्रभारी द्वारा विधिवत् प्रतिहस्ताक्षर कराकर रेफर किये गए अस्पताल से चिकित्सा विभाग में जमा कराये।

In referred cases, the application duly countersigned by Controlling Officer/Subordinate Incharge should be submitted to the Medical Establishment from where he/she was referred.

रेफर न किए गए मामलों में आवेदन को नियंत्रण अधिकारी/अधीनस्थ प्रभारी द्वारा विधिवत् प्रतिहस्ताक्षर कराकर संबंधित कार्मिक शाखा, चिकित्सा प्रतिपूर्ति मामले को निपटाने हेतु स्थापित की गई सैल में जमा कराये।

In un-referred cases, the application duly countersigned by Controlling Officer/Subordinate Incharge should be submitted to the 'P' Branch concerned, to the cell set-up for the purpose of handling Medical Reimbursement case.

(केवल कार्यालय प्रयोग हेतु)

(For Official Use only)

- (i) रेलवे बोर्ड को भेजे जाने वाले सभी मामलों में।
In case of all cases being sent to Board.
- (ii) बिना रेफर किये हुए/अशासकीय अमान्यता प्राप्त मामलों के लिए अपर महा प्रबन्धक की स्वीकृति हेतु।
In case of AGM's sanction for unreferred/Non Govt. unrecongised cases.
1. मु.चि.अधि. के शब्दशः विचार
Verbatim view of C.M.D.
 2. वित्त सलाहकार एवं मु.ले.अधि. के शब्दशः विचार
Verbatim view of FA & CAO
 3. मु.का.अधि. के हस्ताक्षर
Signature of C.P.O.

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.....)

[illegible]

प्राधिकृत चिकित्साधिकारी के हस्ताक्षर
Signature of Authorised Medical Officer

चिकित्साधिकारी/अस्पताल के इंचार्ज के हस्ताक्षर
Signature of the Medical Officer/Incharge of
the case of the Hospital

पैरा 659 देखें
See Para 659
चिकित्सा विभाग
MEDICAL DEPARTMENT
आवश्यकता प्रमाण-पत्र
ESSENTIALITY CERTIFICATE

मैं यह प्रमाणित करता हूँ कि श्री/श्रीमति/कुमारी.....

पत्नी/पुत्र/पुत्री..... जो.....
Wife/Son/daughter..... of
में नियोजित है..... अस्पताल में मेरे परामर्श कक्ष में.....

..... से तक रोग का इलाज मुझसे कराते रहे हैं और
the hospital for disease from to
इस सम्बंध में मेरे द्वारा निर्देशित निम्नलिखित दवाएं रोगी के निरोग होने / उसकी हालत में गंभीर गिरावट की रोकथाम
and that the under mentioned medicines prescribed by me in this connection were के लिए अनिवार्य थी ।
essential for the recovery/prevention of serious deterioration in the condition of the patient.
प्राइवेट रोगियों को आपूर्ति के लिए ये दवाएं अस्पताल में स्टॉक में नहीं रखी जाती

और इनमें ऐसी स्वामित्व वाली मदें शामिल नहीं हैं, जिनके लिए सामान चिकित्सा महत्व वाली सस्ती चीजें उपलब्ध हैं
और न ही ऐसी मदें शामिल हैं जो मूलतः खाद्य पदार्थ, या विसंक्रामक हों for supply to private patients cheaper substances
of equal the therapeutic value are available, nor preparations, which are primarily foods, toilets or disinfectants.

संख्या
No.

दवा का नाम
Name of Medicines

मूल्य
Price

प्राधिकृत चिकित्साधिकारी के हस्ताक्षर तथा पद
Signature & Designation of the Authorized
Medical Officer

दिनांक/Date :

स्थान/Place :

चिकित्साधिकारी/अस्पताल के ईंचार्ज के हस्ताक्षर
Signature of the Medical Officer/Incharge of
the case of the Hospital