PROCESS FOR CLAMING OF MEDICAL REIMBURSEMENT BY THE CLAIMIANT AND DOCUMENTS REQUIRED AT THE TIME OF SUBISSSION

1. **Reimbursement claim form (Available in Eastern Railway's website.)**
2. **The claim should be prepared in three sets (one original file and two Xerox copies). Two sets (one original and one Xerox) are to be submitted, while the third set should be retained by the claimant for record purposes as receipt copy.**
3. **Reimbursement claim is to be submitted within 06 months of treatment /Investigation**
4. **Application from employee /claimant addressed to MD/CMS of the hospital where UMID card /RELHS card (in case UMID card not generated yet of retired employees.) is registered.**
5. **Whether case referred by Railway authority, if yes attach referral letter.**
6. **Original Hospital bill, Medicine bills Investigation bills by treating private doctor with Rubber Stamp.**
7. **Original Investigation Bills by treating private doctor with Rubber Stamp.**
8. **Hospitals bill detailed break up as per claim form.**
9. **Original emergency certificate issued by the hospital, bearing the name, signature, and stamp of the treating doctor.**
10. **Original discharge card/summary /death summary.**
11. **Private hospital case papers issued by the hospital, bearing the name, signature, and stamp of the treating doctor on each and every page.**
12. **Claimed Amount in tabular form with item wise break up of claimed amount.**
13. **Forwarding from concerned department Head / Office / Supervisor if working employee. (in Claim form)**
14. **UMID card / RELHS card (in case UMID card not generated yet of retired employees.) duly attested by gazetted officer**
15. **NEFT /RTGS form with signature and stamp of bank.**
16. **Pay slip / PPO book (attested photo copy)**
17. **Copy of Cancelled blank cheque.**
18. **Xerox copy of Aadhar card**
19. **Numbering of page No. to be done from bottom to top.**

Note: **A DECLARATION IS TO BE GIVEN REGARDING PAYMENT FROM INSURANCE COMPANY FOR THE SAID CLAIM, IF ANY.**

(**Reimbursement Form – INDOOR – NON REFD**.)

To,
The _____,
_____ Hospital,
Eastern Railway,
_____.

Sir/Madam,

Reimbursement of medical expenses incurred by _____ _____ kindly arrange to reimburse the medical expenses incurred by _____ _____ of Rs. _____ (Rupees _____ _____ for doing treatment (_____ _____) at _____ .

In this connection I hereby submit my application with all relevant papers for your kind perusal and necessary action please.

Thanking you,

Yours faithfully,

Dated:

DA: Papers containing _____ Pages.

_____
(Signature of applicant)
Name:
Designation:

Phone No.

1. GR-3 Forms-2 copies, duly filled up & signed by the applicant and forwarded by departmental Officer (for employee) At Page _____.
2. Essentiality Certificate-"A"-02 Nos. &-"B"-02 Nos. for Indoor patient (At Page _____).
3. Original MD/PCMD's Permission letter with photocopy (At Page _____).
4. Original bill with photocopy, duly signed by treating doctor (At Page _____).
5. Photocopy of Medical Identity Card duly attested by Gazetted officer (At Page _____).
6. Photocopy of related Medical Test/Investigation duly attested by Gazetted officer (At Page _____).
7. 01(One) photocopy of Bank cheque leaf.
8. Declaration-Not received any money from any medical insurance company towards this bill.
9. Mandate Form duly signed from Bank.

REIMBURSEMENT CLAIM FORM

I) 1. of the Railway/Retd: Employee _____
(In block letters)

2. Designation of the Railway/Retd: Employee _____
(In block letters)

3. Office & station of employment _____

4. Pay/Last pay of the Railway/Refd. Employee including grade pay _____

5. Residential address _____

6. MIC/RELHS No. and issuing authority _____

7. MIC/RELHS registered at H.Unit/Hospital _____

II) (a) Name & Age of the patient _____

(b) Patient's relationship to the Rly/Retd. Employee _____

III) 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 details bill) _____

f. Whether treatment was taken in emergency _____

g. Are you CTSE member (Y/N) _____

IV) 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 on separate sheet of paper.

V) Total amount claimed _____

VI) Details of bank account where reimbursement amount to be paid.

a. Name of the bank _____ b. Account No. _____

c. Branch MICR code _____ d. IFSC Code _____

VII) List of enclosure [Please tick (√) the documents attached and write additional documents]

a. Photocopy of MIC/RELHS card.
b. Essentially cum emergency certificate by the Non Rly.Hospital.
c. Discharge Summary.
d. Original bills of Hopital.
e. Original cash vouchers of drugs/consumables/inplants etc. if any.
f. Other pouch Stent, pacemaker, implants etc.
g. Any other enclosures _____
(In case of many enclosures, write number of additional enclosure 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 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 health scheme in respect to this treatment episode.

Date:

Place: _____

_____
Signature of the Railway employee

- 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 claim to Rly. With documents; bills etc attested by insurance company.

Eastern Railway
Medical Department

ESSENTIALITY cum EMERGENCY CERTIFICATE

I certify that Shri/Shrimati/Kumar/Kumari _____

Dependent relative of Shri/Shrimati _____ employed in Indian Railway as _____ has been under treatment for _____ _____ disease from _____to _____ at the _____ hospital and that the treatment as described in the attached Discharge Card No. _____ and attached bills hereon 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

Forwarded to the Principal Chief Medical Director together with the enclosures for arranging reimbursement as admissible.

Place:

Date: Head of Department/Divisional/District Officer

Transmitted to PFA&CAO _____ Railway Sanction is accorded to the refund of Rs._____ (Rupees _____ vide coloumns _____ chargeable to

Rs. _____ to _____ Rs. _____ to _____

Rs. _____ to _____ Rs. _____ to _____

A Pay order for the amount drawn in favour of the employee is enclosed to enable him/her to arrange payment (Enclo)

No.

Date: _____
Principal Chief Medical Director

Note:

This application form shall be prepared in duplicate by the employee and the department will forward both copies to:

PCMD who will after sanctioning reimbursement, send the original copy to PFA&CAO. All records for the amount paid to hospital etc.by column 9 should invariably be submitted along with this application. If the details of charges (daily train, pinfold of stay etc_) have not been furnished in the receipts a separate certificate showing the allocation of charges should be submitted to _____ for verification of the amount claimed.

If the treatment was received at a hospital other than Govt. hospital, specified in the annexure to rule 919.11 certificate to the effect that the treatment at that hospital was availed or at the instance of the authorized medical attendant should be submitted to enable the PCMD to consider the application for reimbursement, essentiality certificate in the prescribed form which can be obtained along with this form, the Department should submit in respect of special medicines purchased.

A certificate from the medical officer treating the patient to the effect that the disease of the patient was not one which should be attributed to his/her intemperate habits or conducts should be submitted without which the application for reimbursement will not be considered.

Reimbursement charges paid to Non-Rly Hospital in respect of families of class IV employees is not admissible.

Workshop staff one scale of pay the maximum of which is Rs.60 and below will be treated in the same way as class IV staff as purpose of reimbursement of medical charges under the rules.

N.B. Separate form should be used for each patient.

Recorded parameters to establish the emergency admission
(to be filled in and signed by the treating doctor of the hospital with seal)

A Admission Details.

1. Date and time admission.
2. Admitted through OPO service/emergency service.
3. Admitted to an ICU bed or general bed or cabin bed.

B. Clinical findings at the time of admission. Following findings should be made available and critically evaluated.

Pulse Rate	
BP	
Level of Consciousness	
Any Convulsive feature	
Urine Report	
Ant other feature of shock	
Body Temperature	
Extent of external wound	
Extent of active bleeding	
Extent of Chest pain or Pain in other part(s) of the body	

C. Types of medical treatment given immediately after admission : –

1. List of emergency medicines given immediately after admission : –

_____

2. Type of surgical procedure done immediately after admission.

_____
Seal & Signature of treating doctor

NATIONAL ELECTRONICS FUND TRANSFER (NEFT)
MANDATE FORM FOR RAILWAY EMPLOYEES FOR DIRECT CREDIT TO BANK

1. EMPLOYEE'S NAME :

A) DESIGNATION :

B) DEPARTMENT :

C) BILL UNIT NO. :

D) EMP NO. :

E) RELHS NO. :
(In case of retired employee)

2. PARTICULARS OF BANK ACCOUNT.

A) BANK NAME :

B) BRANCH NAME :

C) IFSC CODE :

D) MICR CODE :

E) S. B. A/C. NO. :

F) COPY OF CHEQUE :

DA: One Photocopy of Bank cheque leaf.

I HEREBY DECLARE THAT THE PARTICULARS GIVEN ABOVE ARE CORRECT AND COMPLETE.

SIGNATURE OF THE CUSTOMER
Phone No.

MANDATE FORM – ECS/EFT

1. Details of Employee/Customer.

   a) Address:

   b) Contract Telephone No., E-mail address (if any):

2. PARTICULARS OF BANK ACCOUNT:

   A) NAME of the Bank :

   B) BRANCH NAME & Address :

   C) Branch Telephone/Fax No. :

   D) Bank Account No. :

   E) Type of Account :

   F) 9-digit MICR code of the Bank :

   G) IFSC Code (For RTGS A/C) :

3. Date of effect:
   I hereby declare that the particulars give above are correct and complete. If transaction is delayed or not affected at all for reasons of incomplete or incorrect information – I would not hold Eastern Railway responsible. I have understood the proposal and agree to discharge the responsibility expected of me as a participant under scheme.

Date:

Signature of the Employee/Customer

Certified that the particulars furnished above are correct as per our record.

Bank Authority's signature with stamp.

Note: Please attach a photocopy of blank cheque for verification of the bank particulars.

(**Reimbursement Form – OUTDOOR – REFD**.)

To,
The _____,
_____ Hospital,
Eastern Railway,
_____.

Sir/Madam,

Reimbursement of medical expenses incurred by _____ _____ kindly arrange to reimburse the medical expenses incurred by _____ _____ of Rs. _____ (Rupees _____ _____ for doing treatment (_____ _____) at _____ .

In this connection I hereby submit my application with all relevant papers for your kind perusal and necessary action please.

Thanking you,

Yours faithfully,

Dated:

DA: Papers containing _____ Pages.

_____
(Signature of applicant)
Name:
Designation:

Phone No.

1. GR-3 Forms-2 copies, duly filled up & signed by the applicant and forwarded by departmental Officer (for employee) At Page _____.
2. Essentiality Certificate-"A"-02 Nos. &-"B"-02 Nos. for Indoor patient (At Page _____).
3. Original MD/PCMD's Permission letter with photocopy (At Page _____).
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7. 01(One) photocopy of Bank cheque leaf.
8. Declaration-Not received any money from any medical insurance company towards this bill.
9. Mandate Form duly signed from Bank.

(IRMM 2000, See Para 653 & Annexure IV)

REIMBURSEMENT CLAIM FORM

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)

I) 1. of the Railway/Retd: Employee _____
(In block letters)

2. Designation of the Railway/Retd: Employee _____
(In block letters)

3. Office & station of employment _____

4. Pay/Last pay of the Railway/Refd. Employee including grade pay _____

5. Residential address _____

6. MIC/RELHS No. and issuing authority _____

7. MIC/RELHS registered at H.Unit/Hospital _____

II) (a) Name & Age of the patient _____

(b) Patient's relationship to the Rly/Retd. Employee _____

III) 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 details bill) _____

f. Whether treatment was taken in emergency _____

g. Are you CTSE member (Y/N) _____

IV) 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 on separate sheet of paper.

V) Total amount claimed _____

VI) Details of bank account where reimbursement amount to be paid.

a. Name of the bank _____ b. Account No. _____

c. Branch MICR code _____ d. IFSC Code _____

VII) List of enclosure [Please tick (√) the documents attached and write additional documents]

a. Photocopy of MIC/RELHS card.
b. Essentially cum emergency certificate by the Non Rly.Hospital.
c. Discharge Summary.
d. Original bills of Hopital.
e. Original cash vouchers of drugs/consumables/inplants etc. if any.
f. Other pouch Stent, pacemaker, implants etc.
g. Any other enclosures _____
(In case of many enclosures, write number of additional enclosure 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 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 health scheme in respect to this treatment episode.

Date:

Place: _____

_____
Signature of the Railway employee

- 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 claim to Rly. With documents; bills etc attested by insurance company.

Eastern Railway
Medical Department

ESSENTIALITY cum EMERGENCY CERTIFICATE

I certify that Shri/Shrimati/Kumar/Kumari _____

Dependent relative of Shri/Shrimati _____ employed in Indian Railway as _____ has been under treatment for _____ _____ disease from _____to _____ at the _____ hospital and that the treatment as described in the attached Discharge Card No. _____ and attached bills hereon 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

Forwarded to the Principal Chief Medical Director together with the enclosures for arranging reimbursement as admissible.

Place:

Date: Head of Department/Divisional/District Officer

Transmitted to PFA&CAO _____ Railway Sanction is accorded to the refund of Rs._____ (Rupees _____ vide coloumns _____ chargeable to

Rs. _____ to _____ Rs. _____ to _____

Rs. _____ to _____ Rs. _____ to _____

A Pay order for the amount drawn in favour of the employee is enclosed to enable him/her to arrange payment (Enclo)

No.

Date: _____
Principal Chief Medical Director

Note:

This application form shall be prepared in duplicate by the employee and the department will forward both copies to:

PCMD who will after sanctioning reimbursement, send the original copy to PFA&CAO. All records for the amount paid to hospital etc.by column 9 should invariably be submitted along with this application. If the details of charges (daily train, pinfold of stay etc_) have not been furnished in the receipts a separate certificate showing the allocation of charges should be submitted to _____ for verification of the amount claimed.

If the treatment was received at a hospital other than Govt. hospital, specified in the annexure to rule 919.11 certificate to the effect that the treatment at that hospital was availed or at the instance of the authorized medical attendant should be submitted to enable the PCMD to consider the application for reimbursement, essentiality certificate in the prescribed form which can be obtained along with this form, the Department should submit in respect of special medicines purchased.

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Reimbursement charges paid to Non-Rly Hospital in respect of families of class IV employees is not admissible.

Workshop staff one scale of pay the maximum of which is Rs.60 and below will be treated in the same way as class IV staff as purpose of reimbursement of medical charges under the rules.

N.B. Separate form should be used for each patient.

CERTIFICATE TO BE OBTAINED FROM AN ATTENDING NON-RAILWAY INSTITUTE FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

CERTIFICATE "A"

(To be completed in the case of patient who os 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 : _____
7. Relation with the Rly. Employee : _____

   (Note: in the cae of children, state age also)
8. Place at which the patient feel ill : _____
9. Nature of illness and its duration : _____

I Dr. _____ hereby certify: –

(a) That the injections administered were for immunizing for prophylactic purpose

(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 the condition of the patient. The medicines are not stocked in the _____ (Name of the hospital/dispensary) for supply to private patient and do not include proprietary preparation for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilet disinfectants.

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

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

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

e) That the X-ray,laboratory test etc for which an expenditure of Rs. _____ was incurred were necessary and were undertaken on my advice at _____ (Name of the hospital/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

Name of the hospital/Dispensary to whom attached

NATIONAL ELECTRONICS FUND TRANSFER (NEFT)
MANDATE FORM FOR RAILWAY EMPLOYEES FOR DIRECT CREDIT TO BANK

1. EMPLOYEE'S NAME :

A) DESIGNATION :

B) DEPARTMENT :

C) BILL UNIT NO. :

D) EMP NO. :

E) RELHS NO. :
(In case of retired employee)

2. PARTICULARS OF BANK ACCOUNT.

A) BANK NAME :

B) BRANCH NAME :

C) IFSC CODE :

D) MICR CODE :

E) S. B. A/C. NO. :

F) COPY OF CHEQUE :

DA: One Photocopy of Bank cheque leaf.

I HEREBY DECLARE THAT THE PARTICULARS GIVEN ABOVE ARE CORRECT AND COMPLETE.

SIGNATURE OF THE CUSTOMER
Phone No.

MANDATE FORM – ECS/EFT

1. Details of Employee/Customer.

   a) Address:

   b) Contract Telephone No., E-mail address (if any):

2. PARTICULARS OF BANK ACCOUNT:

   A) NAME of the Bank :

   B) BRANCH NAME & Address :

   C) Branch Telephone/Fax No. :

   D) Bank Account No. :

   E) Type of Account :

   F) 9-digit MICR code of the Bank :

   G) IFSC Code (For RTGS A/C) :

3. Date of effect:
   I hereby declare that the particulars give above are correct and complete. If transaction is delayed or not affected at all for reasons of incomplete or incorrect information – I would not hold Eastern Railway responsible. I have understood the proposal and agree to discharge the responsibility expected of me as a participant under scheme.

Date:

Signature of the Employee/Customer

Certified that the particulars furnished above are correct as per our record.

Bank Authority's signature with stamp.

Note: Please attach a photocopy of blank cheque for verification of the bank particulars.