

ANNEXURE -II

DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME
REVISED MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF DGEHS
BENEFICIARIES

(To be filled by the claimant)

1. DGEHS Card No. and Place of issue :
2. Validity of DGEHS Card : from..... to
3. Ward Entitlement (if Admitted in Hospital): Pvt. / Semi Pvt. / General
4. Full name of Employee/Beneficiary (Block letters):
5. Full address:
6. Telephone No. (o).....(R).....(M).....
7. E-mail address if, any.
8. Name of the Bank.....Branch.....SB A/c. No.....
Branch MICR Code.....ISF Code.....Tel. No. of Bank Branch.....
9. Name of the patient & relationship with the card holder.....
10. Basic Pay (excluding grade pay).....
11. Name of the Hospital with address:
 - a) OPD treatment (Investigations) & period of treatment
 - b) Indoor treatment: Date of admission.....Date of discharge.....
- 12.

Total amount claimed	Consultation Charges	Investigation charges	Medicine charges	Other charges
For OPD Treatment				
For Indoor Treatment				

13. Details of Referral :
14. Details of Medical advance, if any:.....

DECLARATION

I hereby declare that statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependant on me. I am a DGEHS beneficiary and the DGEHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated:

Signature of DGEHS card holder

Note: Misuse of DGEHS facilities is a criminal offence. Suitable action including cancellation of DGEHS Card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.

INFORMATION

a) Obtain Break up of Investigations from the hospital (details and rates of Individual tests and the exact number of Sugar tests, X-ray films, etc..) as the reimbursable amount is calculated as per approved rates only.

b) Draft against column (I) of check list – in case of loss of Original Papers

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper

I,.....son/wife/daughter of.....and resident oflost/misplaced/not traceable. I hereby give an undertaking that I have not received any payment against original bills/claim papers from any source and that if the original papers are traced I shall not stake claim against original bills in future and that in the event. I receive any cheque against original bills in future I shall return the same to competent authority.

Deponent

Verified by Notary Public

c) Draft against column (I) of check list-In case of Death of Card holder

Draft for Affidavit on Stamp Paper for claiming medical reimbursement

I,.....wife/son/daughter of Late.....and resident ofhereby submit the medical claim papers pertaining to treatment of my father/mother/.....Late Shri/Smt.....who has expired on(copy of Death Certificate is enclosed).

Late Shri/Smt.....has left behind the following other legal heirs none of whom have any objection if the entire amount reimbursable is paid to me.

.....
.....

No5 Objection Certificate signed by other legal heirs on Stamp paper is enclosed.

Deponent

Deponent

Attested by Notary Public

Draft for No Objection Certificate on Stamp Paper.

We.....S/o d/o Late Shri.....

.....S/O d/o Late Shri.....

being the legal heirs of Late Shri.....have no objection if the entire amount reimbursable pertaining to the treatment of our father is paid to our brother Shri.....

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Address

W/o

Address

Verified by Notary Public