FORM C

Application Form for settlement of claim for reimbursement

(To be filled in by the applicant)

To
The Principal/ Vice Principal/ Teacher-In-Charge
Sovarani Memorial College
Howrah

Sir/Madam,

I, , attached to **Sovarani memorial College** , District Howrah ,under Department of Higher Education, Government of West Bengal, do hereby furnish the reimbursement claim coming under the West Bengal Health Scheme for the beneficiaries of Grant -in -aid Colleges and Universities, 2017.

The particulars of the claims are as follows:

1. Health Scheme Beneficiary ID No. of Employee :
2. Full name of the Employee with designation (in Block letters) :

3. Full Address :
   i) College **: Jagatballavpur, Howrah – 711408 , West Bengal.**
   ii) Residency :

4. Name of the Patient :
5. Relationship with the Employee:
6. Health Scheme Beneficiary ID of Patient:
7 Pay (Band Pay + Grade Pay)
8. Name of the Hospital with address :

9. Total amount claimed : Rs;
   a) For OPD treatment : Rs
   b) For Indoor treatment : Rs
   c) For Indoor and Indoor related OPD Treatment :Rs
10. Date of Admission:
    Date of Discharge :

11. Details of permission (if required):
12. Details of Medical advance, if any :

Declaration

I hereby declare that the 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 dependent on me. 1 am a beneficiary of the West Bengal Health Scheme for the beneficiaries of Grant -in -aid Colleges and Universities, 2017 and the Enrolment Certificate issued under the Scheme was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Date :

Signature of Employee/ Claimant

Relation With Employee

FORM D

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist

(to be submitted in duplicate)

(Strike out whichever is not applicable)

1. Health Scheme Beneficiary ID of Patient:
2. Name of the patient and relationship with employee:

3. Name of Hospital, address and Code, if any:

4. Whether Hospital is Empanelled under WBHS or Not:
5. Total amount claimed : Rs

(A) For OPD Treatment : Rs.

(B) For Only Indoor Treatment: Rs

(C) For Indoor and Indoor related OPD :Rs

(A) OPD Treatment Details:

(1) **Name of OPD Disease [As mentioned in 6(1) clause of Notification No.1020- Edn(CS) dt 08.03.19]** :

(II) Date of OPD consultation:

(III) Total No. of vouchers:

(IV) Amount claimed : Rs;

(Indicate serial number of individual vouchers with name and address of the shops with date against each sub- heading in a separate annexure wherever required)

(Rs.)	Amount Claimed (Rs.)	Amount Admissible [To be filled up by office College]
(a) **Consultation fees** .(Specify number of consultations)		
(b) **Cost of pathological and Radiological Investigations**. (Give break up in a separate annexure with code no.)		
(c) **Cost of Medicines**. (Give details of purchase in separate annexure)		
(d) **Cost of Consumables**. (Give details of purchase in separate annexure)		
(e) **Miscellaneous (specify)**		

Sectional Total of SL.(A) : Rs

IB) Indoor Treatment Details:

(To be marked N.A. wherever necessary)

(Details of Hospital Bill and other vouchers pertaining to the period of indoor treatment)

(a) **Period of Bill : From** **To**

(b) **Amount claimed for**

i) **Package Treatment** :

ii) **Non-Package Treatment**:

(indicate serial number of individual vouchers with name and address of shops with date against each sub- heading in a separate annexure wherever required)

(I) **for Package treatment** : from to : [Code start with '01']

Sl. No. (1)	Procedure Code (2)	Procedure Name (3)	Amount Claimed(Rs) (4)	Amount Admissible [To be filled up by office of College]

(II**)** **for Non-Package treatment** : from to

	Amount Claimed (Rs.)	Amount Admissible (Rs.) [To be filled up by Office of College]
(i) **Consultation Fees.** **(Specify number of consultations)**		
(ii) **Room Rent**.		
Ward : From To:		
IGU/ICCU/ITU/ PICU/NICU: From: To:		
HDU/SDU/ Burn Unit : From: To:		
CRIB (Critical Ward Bed) : From: To:		
(iii) **Cost of pathological and radiological Investigations.** (Give break up in a separate annexure with code no.)		
(iv**)** **Cost of Medicines.** (Give details of purchase in separate annexure)		
(v) **Cost of Consumables .** (Give details of purchase in separate annexure)		
(vi) **Cost of Implants**.		
(vii) **Artificial Devices**.		
(viii) **Special Nursing** (Give details in Separate annexure)		
(ix) **Miscellaneous (If Any)** (Give details in Separate annexure)		
Total:		

Sectional Total of Sl. (B) [(I) + (II)] : Rs.

(C**) Indoor Related OPD Treatment (includes 30 days' prior admission and 30 days after discharge):**

(I) **Dates of Related OPD consultation:**

(II) **Total No. of vouchers**

(III) **Amount claimed**: Rs.

(Indicate serial number of individual vouchers with name and address of the shops with date against each sub- heading in a separate annexure wherever required)

	Amount Claimed (Rs.)	Amount Admissible (Rs.) [To be filled up by office of College]
(a**)** **Consultation fees.** **(Specify number of consultations)**		
(b) **Cost of pathological and radiological Investigations.** (Give break up in a separate annexure with code no.)		
(c) **Cost of Medicines**. (Give details of purchase in separate annexure)		
(d) **Cost of Consumables.** (Give details of purchase in separate annexure)		
(e) **Miscellaneous (specify)**		
Total: Rs.		

Sectional Total of SL.(C) (Rs.) Total claim [Either only (A) or (B) or (B) + (C)]

(Signature of Claimant)

Name in Block Letters with Health Scheme beneficiary ID (if available)

Relationship with Employee: Address :

1. Certified that the relevant bills/vouchers have been verified by me as per latest approved rates of the WBHS, 2008 and the expenditures shown above are correct and the treatment services provided were essential and minimum that required for the recovery of the patient.
2. Certified that the treatment was done in an organization having number of beds and having a License under the West Bengal Clinical Establishment Act and Rules bearing no. . The License is valid up to
3. Certified that the patient, was/ has been suffering from as listed in SI. No. of the WBHS OPD.
4. was performed
5. Conservative treatment provided from to
6. Certified that the patient had been admitted/consulted under at
7. Certified that the relevant bills/vouchers have been verified by me and the expenditure shown is correct and the treatment services provided were essential and minimum that was required for the recovery/stabilization of the patient.

Signature of the Treating Specialist
with office Seal

Signature
Medical Superintendent/Administrative officer
…………………………………………………………………Hospital
Official Seal

FORM E

Checklist For Reimbursement of Medical Claims

1. Name of Patient (BLOCK Letters)

2. Relationship with employee

3. Health Scheme Beneficiary ID No. of the patient

4. Entitlement Private/Semi-Private:

5. Full name of Employee (BLOCK letters):

6. Designation of Employee:

7.The following documents are submitted (please tick the relevant column)

a)	**Photocopy of the Enrolment Certificate**	**YES/NO**
b)	**Essentiality Certificate**	**YES/NO**
c)	**Number of original bills**	**YES/NO**
d)	**Whether original bills/vouchers have been verified**	**YES/NO**
e)	**Copy of discharge summary**	**YES/NO**
(f)	**Copy of permission letter**	**YES/NO**
(g)	**Whether the hospital has given break up for lab investigations**	**YES/NO**

(i)In case of Original papers have been lost the following documents are submitted

(I)	**Photocopies of claim paper**	**YES/NO**
(II)	**Affidavit on stamp paper**	**YES/NO**

(ii) In case of death of Employee the following documents are submitted:

(I)	**Affidavit on stamp paper by claimant**	**YES/NO**
(II)	**No objection from other legal heirs on stamp papers**	**YES/NO**
(III)	**Copy of death certificate**	**YES/NO**

Dated............................. **Signature of the Applicant**

Relationship with Employee