REIMBURSEMENT CLAIM FORM

1) Name of the Railway/Retd. employee (in BLOCK Letters) _____
2) Designation of Railway/Retd. employee (in BLOCK Letters) _____
3) Office & Station of employment _____
4) Pay/Last Pay of the Railway/Retd. Employee including grade pay _____
5) Residential address _____
6) MIC/RELHS no. & issuing Authority _____
7) MIC/RELHS register at H. Unit/Hospital _____

II A Name & Age of the patient _____
B Patient's relationship to Rly./Retd. employee _____

III Details of Indoor Treatment at Non-Railway Institute
A Name of Hospital: _____
B Date of Admission: _____
C Date of Discharge: _____
D Diagnosis: _____
E Amount of Total Hospital Bill (Attached detailed bill): _____
F Weather Treatment was taken in Emergency: _____
G Are you a 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 is to be paid:
a) Name of Bank b) Account No.
c) Branch MIRC Code d) IFSC Code.

VII List of enclosures (Please Tick the documents attached and write additional documents)

A Photocopy of MIC/RELHS Card
B Essentiality cum Emergency Certificate by the Non Rly. Hospital
C Discharge Summary
D Original Bills of Hospital
E Original Cash Vouchers of Drugs/consumables/ Implants etc. if relevant
F Outer Pouch of Stent, pacemaker, Implants
G Any other enclosures _____
(In case of many enclosures, write number of additional enclosures here and attach a separate sheet with details)

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. 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 declared that this is my final claim and I shall not make any claim in future to Railway or any other health scheme in respect to this treatment episode.

_____
Signature of the Railway employee

Date:_____.
Place:_____

In case the beneficiary has medical insurance policy and intent to make claim for the treatment in question then he/she may make claim to insurance company first and then submit claim to Railway with documents, bills etc. attested by insurance company.

_____ RAILWAY

MEDICAL DEPARTMENT

ESSENTIALITY-CUM-EMERGENCY CERTIFICATE

I certify the Shri/Shrimati/Kumar /Kumari _____ wife/son/ daughter/ dependent relative of Shri/Shrimati _____, has been under my treatment for _____ disease from _____ to _____ at the _____ hospital and that the treatment as described in the attached discharge card No. _____ and attached bills thereon 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