

FORM I
Application for enrolment
[See sub-para (iv) of para-4 of memo no. 3475 F dt. 11.05.09.]

To
The..... (Pension Sanctioning Authority)

Dear Sir,

I, along with my dependent family members whose particulars are given below at Sl. No. 12 may please be enrolled under the West Bengal Health Scheme, 2008 with effect from 1st day of(month).....(year). /

I family pensioner along with dependent family members of my late husband/ wife, Ex-Govt. employee at Sl. No. 12 may be enrolled under the West Bengal Health Scheme, 2008 w.e.f. 1st day of(month).....(year).

(* Strike out whichever is not applicable)

My particulars are given below

1. Name of the Ex-Govt. Employee :
2. Residential Address :
3. Date of Retirement/Death :
4. Department/ Office where rendered services :
5. Last Pay (Band Pay+ Grade Pay) drawn before retirement/ death :
6. Basic Pension(before commutation) :
7. Pension Payment Order No. :
8. Name of Treasury with address (In case of Pensioners residing in the districts) :
9. Name of Bank with account no. and address (In case of Pensioners residing in Kolkata) :
10. Whether a beneficiary of the Health Scheme during service period :
11. Identification no. under the Health Scheme during service period before retirement/ death :
12. Details of Family :

Sl. No.	Name	Date of birth/Age	Relationship	Monthly income, if any
1.				
2.				
3.				
4.				
5.				

I do hereby declare that upon enrolment under the above scheme I shall forgo the regular medical relief drawn by me as part of pensionary benefits.
I further declare that I shall abide by the provisions of the West Bengal Health Scheme, 2008 as may be in force from time to time.

Signature of the Applicant

FORM II
Certificate of enrolment

[See sub-para (v) of para-4 of memo no. 3475 F dt. 11.05.09.]

Certified that Shri/ Smt _____, Ex
_____ who was attached to
_____ (office) under
_____ Department has been enrolled under the West
Bengal Health Scheme, 2008, with effect from 1st day of _____ (Month),
_____ (Year)/

Certified that Shri/ Smt _____, family pensioner has been
enrolled under the West Bengal Health Scheme, 2008, with effect from 1st day of
_____ (Month), _____ (Year)

(* Strike out whichever is not applicable)

The particulars of the Ex-Govt. employee and members of family as defined in
para 3(v) of memo no. 3475-F dt.11.05.09 read with memo no. 7071-F, dt. 20.07.09 are
as follows:-

13. Name of the Ex-Govt. Employee :

14. Residential Address :

15. Date of Retirement/ Death :

16. Department/ Office where rendered :
services

17. Last Pay (Band Pay+ Grade Pay) drawn
before retirement/ death :

18. Basic Pension (before commutation) :

19. Pension Payment Order No. :

20. Name of Treasury and Bank with
address from where pension is drawn :
(In case of Pensioners residing in the
districts)

21. Name of Bank with account no.

and address :

(In case of Pensioners residing in Kolkata)

22. Identification no. under the Health :

Scheme during service period

before retirement/ death

23. Details of Family :

Sl. No.	Name	Date of birth/Age	Relationship	Monthly income, if any
1.				
2.				
3.				
4.				
5.				

Signature of the Pension Sanctioning Authority

Copy forwarded for information and necessary action to:

1. Shri/ Smt _____ (Ex. _____ / family pensioner)

2. The Treasury Officer _____ Treasury _____ (address).

He is requested to discontinue the drawal of regular medical relief in respect of Shri/ Smt _____ with effect from 1st day of _____ (Month), _____ (Year).

3. The Branch Manager, _____ Bank _____ (address).

4. The Accountant General (A & E), West Bengal, Treasury Buildings, Kolkata-700001.

5. Medical Cell, Finance (Audit) Department, Writers' Buildings, Kolkata- 1.

FORM III

Application Form for settlement of claim for reimbursement.

(See sub-para (i) of para 11 of memo no. 3475 F dt. 11.05.09.)

(To be filled in by the applicant)

1. Identification No. :
2. Full name of Govt. Pensioner / Family Pensioner :
(in Block letters)
3. Full Address:
 - (i) Office (from where retired)/ :
Pension Sanctioning Authority
 - (ii) Present Residence :
4. Enrolment under the Health Scheme w.e.f. :
5. Last Pay Drawn (Band Pay + Grade Pay)/ Basic Pension :
6. Medical treatment done : Self or beneficiary
7. Name of the beneficiary & relationship with
the Ex-Govt. employee :
8. Accommodation Category (Put tick mark) : Private/Semi-Private/General Ward
9. Name of the Hospital with address & code no.
 - (i) OPD treatment :
 - (ii) Indoor treatment/ Day Care :
10. Period of O.P.D. treatment :
11. Period of indoor treatment :

12. Disease :
13. Total amount claimed –
- (i) OPD treatment :
 - (ii) Indoor treatment :
14. Details of permission
- (i) For treatment in Speciality Hospital outside the State :
 - (ii) For human organ transplantation/ ICD/ CRT/ Dual Chamber Pacemaker/ more than two drug eluting stents, etc. :
15. Details of Medical advance, if any
(only for treatment in Govt. Hospital)
- (i) Amount sanctioned :
 - (ii) Order no. and date :
 - (iii) Sanctioning Authority :
 - (iv) D.D.O. :

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. I am a beneficiary of the West Bengal Health Scheme, 2008, and card 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 Govt. Pensioner /
Family Pensioner***

FORM "IV₁"
Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist
for OPD Treatment

[See sub-para (ii) of para 11 of the memo no. 3475 F dt. 11.05.09.
and clause-7 (1) of the Health Scheme]

1. Name of the Govt. pensioner/ family pensioner
with identification No. :

2. Name & address of Office of the Ex-Govt. employee/
Govt. Pensioner/ Pension Sanctioning Authority :

3. Name of the patient, relationship with Ex-Govt. employee
& identification No. :

4. Details of expenditure:
 - (I) Name of the diagnosed disease :
*
(vide list enclosed)

 - (II) Name & Code No. of the empanelled/ recognised Hospital :

 - (III) Period of OPD treatment :

 - (IV) Total No. of original bills & vouchers :

<u>Sl. No.</u>	<u>Description of items</u>	<u>Amount Claimed</u>	<u>Amount admissible (for official use)</u>
(a)	Consultation fees (indicate total no. of consultations)		
(b)	Laboratory charges (give Break-up in a separate annexure with code no.)		
(c)	Radiological investigations (attach separate list, if required, with code no.)		
(d)	Medicines (give details of purchase in separate annexure, if required)		

(e) Special devices like hearing aid/artificial appliances etc. (specify)

(f) Miscellaneous (specify)

Total

(Rupees:

only) (Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the relevant bills/vouchers have been verified by me in pursuance of the latest approved rates of the WBHS, 2008 and the expenditures shown above are correct and the treatment services prescribed and provided were essential and minimum that required for the recovery of the patient.

2. Certified that the patient, Sri/Smt. _____ was/ has been suffering from _____ as listed in Sl. No. _____ of the WBHS OPD list below.

Counter signed by

(Signature of the Treating Specialist
with official seal)

Administrative officer/Medical Superintendent
of the recognized Hospital with official seal

*** OPD Disease List as per clause –7(1) of the WBHS, 2008**

(i) Malignant diseases,

(ii) Tuberculosis,

(iii) Hepatitis B/C and other liver diseases,

(iv) Insulin-dependent diabetes,

(v) Heart diseases,

(vi) Neurological disorders/Cerebrovascular disorders,

(vii) Malignant malaria,

(viii) Renal failure,

(ix) Thallasaemia/Bleeding disorders/Platelet disorders,

(x) Injuries caused by accidents.

(xi) None of the above list (Specify name of the ailment)

[vide Para-10 of Memo No. 797-F (MED), dated 31-01-2011]

FORM "IV₂"

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

for Indoor/Day Care Treatment and related OPD treatment

[See Para-5 of Memo. No.3475-F Dt.11.5.09, Clause6, Clause-7 (2)]

1. Name of the Govt. Pensioner/family pensioner with identification No. :
2. Name & address of Office of the Ex-Govt. Employee/ Pension Sanctioning Authority :
3. Name of the patient, relationship with Ex-Govt. Employee & identification No. :
4. Details of expenditure:
 - (I) Name of the diagnosed disease :
 - (II) Name, Code No. & Class of the empanelled/ recognised Hospital :
 - (III) Period of Indoor/Day Care treatment :
 - (IV) Total No. of original bills & vouchers :
 - (V) **Details of Amount claimed**
 - (A) **for Package treatment from _____ to _____ :**

<u>Sl No.</u>	<u>Procedure Name</u>	<u>Procedure Code No.</u>	<u>Package Period (from – to)</u>	<u>Amount Claimed (Rupees)</u>	<u>Amount admissible (Rupees) (for official use)</u>
(1)	(2)	(3)	(4)	(5)	(6)
(i)					
(ii)					
(iii)					
(iv)					
(v)	Miscellaneous (Specify & give details in separate sheet, if necessary)				

Total=Rupees

(B) for Non-Package treatment from _____ to _____

<u>Sl. No.</u>	<u>Description of items</u>	<u>Item Code</u>	<u>Period</u>	<u>Amount claimed (Rupees)</u>	<u>Amount Admissible (Rupees) (for official use)</u>
(1)	(2)	(3)	(4)	(5)	(6)
(i)	Room Rent :				
	(a) Ward				
	(b)ICU/ITU/CCU /NICU/PICU				
	(c) HDU/ Step Down Unit				
(ii)	Charges for : (give details with code nos. in separate annexure, if required)				
	(a) Indoor visit of specialist/ super specialist				
	(b) Radiological Investigations				
	(c) Pathological Investigations				
	(d) Medicines				
	(e) Artificial devices				
	(f) Miscellaneous (specify)				
	Total :			=Rupees	

(VI) Related OPD treatment in terms of Clause-9 or Clause-7(2)

<u>Sl. No.</u>	<u>Description of Items</u>	<u>Amount Claimed</u>	<u>Amount admissible (for official use)</u>
(1)	(2)	(3)	(4)
(i)	Consultation fees (indicate total no. of consultations)		
(ii)	Charges for: (give details with code nos. in separate annexure)		
(a)	Pathological investigations		

- | | | | |
|-----|--|-----|-----|
| (1) | (2) | (3) | (4) |
| (b) | Radiological investigations | | |
| (c) | Medicines | | |
| (d) | Special devices like hearing aid/artificial appliances etc.
(specify) | | |
| (e) | Miscellaneous (specify) | | |

Total: =Rupees

Grand Total (package + non-package+ OPD amount) =Rupees

(Rupees: only)
(in words)

(Signature of Claimant)

Name in Block Letters

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 services of Special Nurse/Ayah were required from _____ to _____ that were absolutely essential for the recovery of the patient.

3. Specific procedure/Operation performed was _____ on _____

4. Conservative treatment of _____ (Disease) done from _____ to _____ .

*(Signature of the Treating Specialist
with official seal)*

Countersigned by Medical Superintendent/
Administrative officer of the recognized Hospital with seal

FORM "IV₃"

**Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist
[See Para-23 of the FD memo no. 797-F (MED), dt. 31.01.2011]**

1. Name of the Govt. pensioner/family pensioner with identification No. :
2. Name & address of Office of the Ex-Govt. employee/ Pension Sanctioning Authority :
3. Name of the patient, relationship with Ex-Govt. Employee & identification No. :
4. Details of expenditure:
 - (I) Name of the emergency disease (* vide list enclosed) :
 - (II) Name & Address of the Hospital & code no. :
 - (III) Period of treatment :
 - (IV) Total No. of original bills & vouchers :

Details of Amount claimed:

(give details in separate annexure, if required)

Sl. No.	Description of items	Treatment Period	Amount claimed (Rupees)	Amount Admissible (60% of approved Package rate) (Rupees) (for official use)
(1)	(2)	(3)	(4)	(5)
(i)	Operation			
(ii)	Delivery			
(iii)	Removal of foreign body			
(iv)	Haemodialysis			

Total= Rupees _____

(Rupees :
(in words)

only)

(Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the patient had been admitted under my care at _____ Hospital/Nursing Home as an emergency case. The Specific procedure/Operation performed was _____ on _____.
2. 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.
3. Certified that the treatment was done in an organization that has a License under the West Bengal Clinical Establishment Act and Rules and the licence no. is _____ and is valid up to _____.

Countersigned by Medical Superintendent/
Administrative officer of the Hospital with seal

*(Signature of the Treating Specialist
with official seal)*

***List as per Para 23 of Memo No. 797-F (MED), dt. 31-01-2011**

- (a) Accidental injury,
- (b) Acute Appendicitis operation on emergency basis,
- (c) Delivery on emergency basis,
- (d) Haemodialysis,
- (e) Removal of foreign body on emergency basis.

FORM V
Checklist For Reimbursement of Medical Claims
[See sub-para (ii) of para 11 of memo no. 3475 F dt. 11.05.09.]

1. Pensioner's/Family Pensioner's Identification No. & date of enrolment :
2. Full name & designation (block letters) :
3. (a) Name of office with address :
(b) Directorate :
(c) Department :
4. Whether claim is for pensioner/family pensioner himself or his beneficiary, if for his beneficiary, mention – : Yes/No
a) Name of the beneficiary and relationship with pensioner :
b) Beneficiary's Identification No. :
c) Validity of the Card upto :
5. Entitlement of accommodation : Private/Semi-Private/General ward
6. Disease :
7. Name of the hospital where treatment was done/ to be done :
8. Whether treatment was done in non-empanelled hospital : Yes/No
If yes –
a) Name of the hospital/nursing home with Clinical Establishment licence No. and address :
9. Period of treatment: a) OPD : from _____ to _____
b) Indoor/Day Care treatment : from _____ to _____
10. Details of advance sanctioned (if any) -
a) Amount :
b) Order No. & date :
c) Sanctioning Authority :
d) D.D.O. :
11. a) Treatment done within the State-
(i) Copy of intimation letter furnished : Yes/No.
(ii) Copy of permission letter furnished : Yes/No.
(For human organ implantation/ Dual-chamber pacemaker/ AICD/ CRT/ more than one drug eluting stents Implantation, etc.) (Vide Para-8 & 9 of Finance Deptt. Notification No. 796-F (MED), dated 31-01-2011)

- b) Treatment done outside the State –
Copy of permission letter furnished : Yes/No.
12. (a) Whether the claim for reimbursement has been preferred within
- (i) three months from the date of discharge of indoor treatment :
(ii) three months from the date of consultation of OPD treatment :
(iii) three months from the date of purchase of medicines, etc. :
(for continuous OPD treatment)
- (b) If not, whether delay in preferring claim has been condoned
by the West Bengal Health Scheme Authority
under the Finance Department :
13. The following documents are submitted
(please tick [√] the relevant column)--
- (a) Photocopy of the Health Scheme identity
Card of I) Govt. Pensioner/family pensioner : Yes/No.
II) Beneficiary : Yes/No
- (b) Essentiality Certificate (as specified) : Yes/No.
- (c) Copy of discharge certificate : Yes/No.
- (d) Copy of OPD prescription : Yes/No.
- (e) Total Number of original bills & cash memos/ money receipts : Yes/No.
- (f) Detailed list/Statement of medicines furnished : Yes/No
- (g) Detailed list of investigations furnished : Yes/No
- (h) Original papers have been lost the following documents are submitted-
- (I) Photocopies of claim paper : Yes/No.
(II) Affidavit on stamp paper : Yes/No.
(III) Photo copy of Police Diary : Yes/No.
- (i) In case of death of Govt. Pensioner/ Family Pensioner
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

FORM- VI
Temporary Family Permit

[See sub-para (vii) of para-7 of memo no. 3475-F dt. 11.05.09]

1. Name of the Govt. Pensioner/ Family Pensioner :
2. Pensioner Identification No. (P.P.O. No.) :
3. Last designation :
4. Last Pay (Band Pay + Grade Pay)/ Basic Pension :
5. Entitlement of accommodation :
6. Date of Birth :
7. Date of retirement/ death :
8. Residential address :
9. Details of Family :

Sl. No.	Name	Age	Relationship	Monthly income, if any	Photograph (Stamp size)
1.					
2.					
3.					
4.					
5.					

Shri/Smt. _____ last attached to _____ (office)
under _____ Department has been enrolled under the
West Bengal Health Scheme, 2008 with effect from _____
He/She and his/her family members are entitled to the medical attendance and treatment
in a Government Hospital/empanelled Private Hospital or Institution etc. recognised under the
West Bengal Health Scheme, 2008 in the entitled class mentioned in Sl. No. 5.

This permit is valid for 6 (six) months from the date of enrolment.

Signature of Cadre controlling authority
/Head of the office.