Government of West Bengal
Department of Agriculture
Education Branch
Block-III, 2 nd Floor,
Writers' Buildings, Kolkata – 700 001

NOTIFICATION

No. 2080 -AG-12019(15)/7/2020-EDU SEC **Date: 07.06.2021**

The undersigned is directed to say that the Governor is hereby pleased to extend the benefits of " **West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department"** to the serving permanent Teachers/Officers and their dependant family members of Bidhan Chandra Krishi Viswavidyalaya (BCKV) and Uttar Banga Krishi Viswavidyalaya (UBKV) and College of Agriculture under both Universities in the following manner under the scheme detailed below.

Scheme

1. **Short title and commencement** - (1) This Scheme may be called " **West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department"** .
2. It shall come into force with effect from the date of issue of the Notification.

2. **Application** – (1) This scheme shall apply to the serving permanent Teachers and Officers of Bidhan Chandra Krishi Viswavidyalaya (BCKV) and Uttar Banga Krishi Viswavidyalaya (UBKV) and College of Agriculture under them and their dependent beneficiaries.

(2) The provision of enrolment under this scheme shall be optional.

(3) This scheme will be implemented in reimbursement mode only.

(4) A teacher/officer shall not be entitled to draw the regular medical allowance, if opted for this scheme with effect from the date of effect of such enrolment.

(5) A teacher/officer shall have the liberty to opt out of this scheme at any time by applying through WBHS using his/her individual login. Provided that a teacher/officer shall not be allowed to opt out from scheme within five years from the month following the month in which she / he or his / her beneficiary enjoyed the benefit under the scheme.

3 . **Definitions** – In t his scheme unless there is anything repugnant in the subject or context .

(a) "Approved Rates" means such rates as may be notified by Finance Department, Government of West Bengal applicable for West Bengal Health Scheme from time to time for various services, procedures and investigations required in connection with the medical attendance and treatment of a beneficiary.
(b) "Beneficiary" means a dependent member of the family of a serving teacher/officer.

(c) "Clause" means a clause of the scheme.

(d) "Institutions" means Bidhan Chandra Krishi Viswavidyalaya (BCKV) and Uttar Banga Krishi Viswavidyalaya (UBKV).

(i) "Head of Institution" means the respective Vice-Chancellor of Bidhan Chandra Krishi Viswavidyalaya (BCKV) or Uttar Banga Krishi Viswavidyalaya (UBKV).

(ii) " Recommending Authority" means any officer having rank in the middle tier of the Institution.

(iii) "Operator" means any clerical staff (LDC/UDC) of the Institution.

(e) "Administrative Department" means Agriculture Department, Government of West Bengal.

(i) " Head of the Department" means Addl. Chief Secretary/Principal Secretary/Secretary of the Administrative Department.

(ii) "Delegated Approver" means Deputy Secretary/Joint Secretary/Additional Secretary of the Administrative Department.

(iii) "Verifying Authority" means any official/Assistant of the Administrative Department.

(f) (i) 'Teacher' means full time and regular serving Teachers including Librarians and Graduate Laboratory Instructors of Bidhan Chandra Krishi Viswavidyalaya (BCKV) and Uttar Banga Krishi Viswavidyalaya (UBKV) under Agriculture Department, Govt. of West Bengal enrolled under clause 2.

(ii) "Officer" means serving officers of Bidhan Chandra Krishi Viswavidyalaya (BCKV) and Uttar Banga Krishi Viswavidyalaya (UBKV) under Agriculture Department, Government of West Bengal enrolled under Clause 2.

(g) "Family" in relation to a teacher/officer includes the following;

i. Husband or Wife as the case may be,
ii. Dependent Parents whose monthly income does not exceed rupees three thousand and five hundred.
iii. Dependent Children including step-children, legally adopted children up to the age of 25 years.
iv. Dependent widowed/divorced daughters whose age exceeds 25 years but her monthly income doesnot exceed Rupees one thousand and five hundred.
v. Dependent Minor brothers and sisters up to the age of 18 years.
vi. Dependent unmarried/widowed/divorced sisters whose age exceeds 18 years but her monthly income does not exceed Rupees one thousand and five hundred.
vii. Income (not age) shall not be a consideration when the eligible beneficiaries mentioned with sl. no. (ii) to (vi),stated above are suffering from Critical Illness/Disease as notified by Finance Department, Govt. of West Bengal.

Note:

1. The conditions of beneficiary are not applicable to the spouse. Spouse can be included irrespective of his/her monthly income. But....

a. If both husband or/and wife is/are working/worked in any organisation under direct control of Govt. of West Bengal and is/are eligible to draw Medical Allowance/Relief, they can enrol themselves individually or jointly to their respective health scheme controlled by their Administrative Department. In case of opting in a health scheme jointly in a particular scheme, only the benefit of that scheme is admissible.

b. Again if the spouse is an employee of Central Govt. or PSU Bank or any Corporation/Undertaking financed more than 50% total capital by Central/State Govt. or local bodies or aided institution or private organisation which provides medical facility, she/he to choose any one place for getting medical facility. Therefore, if spouse wants to get benefits under this scheme, an official certificate from his/her employer first regarding relinquishment of medical allowance and benefit available from his/her employer.

2. 'Son' is considered to be dependent till he starts earning or attains the age of 25 years, whichever is earlier. Son /daughter, who is suffering from permanent disabilities either physically or mentally will be considered dependent without any age limit.
3. Son/daughter/sister shall not be considered as beneficiary from the date of their marriage.
4. As an exception, parents can live away from employee in another station with other members of family.
5. A declaration regarding the income of all dependent beneficiaries except spouse shall be furnished biennially by the concerned enrolled teacher/officer in the month of November.

(h) 'Order' means all orders issued by Finance Department, Govt. of West Bengal in connection with implementation of West Bengal Health Scheme in **reimbursement mode** applicable for employees of Govt. of West Bengal and it will be equally applicable for this scheme also.

(i) "Form" means a Form appended to this scheme.

(j) "Government" means Govt. of West Bengal.

(k) "Health Care Organisation (HCO)" means such Govt. or Private Hospital/Nursing Home that may be recognized/empanelled/enlisted from time to time by Finance Department, Govt. of West Bengal for the purpose of availing benefits of medical attendance and treatment under this scheme.

(l) "Laboratory" means such laboratory as may be recognized by the Govt. of West Bengal from time to time for availing of benefits of medical attendance and treatment under this scheme.

(m) "Medical attendance" means for professional advice and includes pathological, bacteriological , radiological or other methods of investigation for the purpose of diagnosis which are considered necessary by the attending physician and are carried out in a hospital.

(n) "Specified" means specified by order.

(o) "Treatment" means the use of medical and surgical facilities and includes.

(i) The employment of such pathological bacteriological, radiological or other methods of investigations which are considered necessary by the attending physician.

(ii) The use of such medicines, vaccines, serum or other therapeutic substances as may be considered necessary by the attending physician.

(iii) Medical and surgical services and procedures.

(iv) Dental treatment.

(v) Such nursing as is ordinarily provided at the hospital or such special nursing at the hospital as the authorized medical attending physician at the hospital may certify, in writing, to be essential for the recovery of for the prevention of serious deterioration in the condition of the patient, having regard to the nature of the disease.

4. **Facilities** – A teacher/officer and his/her dependent beneficiary shall be entitled to get the following facilities, namely:-

(a) Medical attendance and treatment as an indoor patient in a hospital.

(b) Medical attendance and treatment as an Out-Patient Department (OPD) patient in a recognised/empanelled/enlisted hospital, or a clinic attached to such hospital for the diseases specified by competent authority from time to time.

5. **Medical attendance and treatment as an indoor patient in a hospital – A** teacher/officer shall be entitled to get reimbursement of the cost of medical attendance and treatment of him/her and his/her dependent beneficiaries', as an indoor patient in a hospital.

Explanation – For the purpose of the clause the expression "cost of medical attendance and treatment" shall include-

a.

a. The amount charged by the hospital in accordance with the approved rates notified by Finance Department, Govt. of West Bengal.
b. The cost of medicines supplied by the recognised/empanelled/enlisted or purchased from outside on the advice of the attending physician of the hospital provided that the certification of Medical Superintendent on non-availability of such medicine in the store of hospital.
c. The charges for such pathological, bacteriological, radiological or other methods investigations as are considered necessary by the attending physician and carried out, on the advice of the attending physician, in a recognised/empanelled/enlisted hospital/diagnostic centre other than the treating hospital.
d. The cost of Implants and/or Special Devices as prescribed by the treating surgeon/consultant of a hospital where the treatment is going on is reimbursable as per approved WBHS rate or actual basis in case where no prescribed rate exists.
e. The cost incurred on account of related medical attendance and treatment received in recognised/empanelled/enlisted hospital during the period up to 30 days prior to hospitalization and 30 days from date of discharge.

6. Medical attendance and treatment as an OPD (Out-Patient Department) patient in a hospital-

(1) A teacher/officer shall be entitled to get reimbursement of the cost of medical attendance and treatment of him/her and his/her dependant beneficiary's as an OPD patient in recognised/empanelled/enlisted hospital in the following diseases:

a.

i. Malignant diseases (Mainly cancer cases are considered as malignant diseases)
ii. Tuberculosis.
iii. Hepatitis B/C and other liver diseases.
iv. Insulin-dependent diabetes. (Type – 2 Diabetes Mellitus is not considered as Insulin- dependent Diabetes.
v. Heart diseases.
vi. Neurological disorders/ Cerebrovascular disorders.
vii. Malignant Malaria.
viii. Renal failure.
ix. Thalassemia/ Bleeding orders/ Platelet disorders.
x. Injuries caused by accidents. (Animal Bite cases will come under the purview of injuries caused by the accidents.)
xi. Rheumatoid Arthritis.
xii. Systematic Lupus Erythematosus (LUPUS)
xiii. Crohn's Disease.
xiv. Endodontic Treatment (Root Canal Treatment).
xv. Chronic Obstructive Pulmonary Disease (COPD).
xvi. Ankylosing Spondylitis.
xvii. None of the above list [Vide para 10 of 797-F(MED), dated 31.01.2011]

(2) A teacher/officer or his/her beneficiary shall also be entitled to get reimbursement of the cost of follow-up medical attendance and treatment relating to Neuro-Surgery, Cardiac Surgery (including Coronary Angioplasty and

implants), Cancer Surgery/ Chemotherapy/Radiotherapy, Renal Transplant, Hip/Knee replacement Surgery and Accident cases received as an OPD patient in recognised/empanelled/enlisted hospital.

Explanation – For the purpose of this clause the expression "cost of medical attendance and treatment" shall include:

a. The amount charged by the recognised/empanelled/enlisted hospital in accordance with the approved rates.
b. The cost of medicines purchased from outside on the advice of the attending physician of the recognised/empanelled/enlisted hospital.
c. The charges for such pathological, bacteriological, radiological or other methods of investigations as are considered necessary by the attending physician and carried out on the advice of the attending physician in a recognised/empanelled/enlisted hospital or laboratory other than the hospital in which the patient is treated.
d. The cost of Implants and/or Special Devices as prescribed by the treating surgeon/consultant of a recognised/empanelled/enlisted hospital where the treatment is going on is reimbursable as per approved WBHS rate or actual basis in case where no prescribed rate exist.

7 . Enrolment:

(a) A teacher/officer will have to apply online for enrolment under " **West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal"** through **West Bengal Health Scheme Portal** having URL(**https://wbhealthscheme.gov.in**) . New URLs will also be available within the portal for Bidhan Chandra Krishi Viswavidyalaya (BCKV) and Uttar Banga Krishi Viswavidyalaya (UBKV).

(b) At the time of online application, Teacher/Officer has to upload scanned clear photo and signature having size 12-50 kb of all beneficiaries besides other mandatory information. After online submission, s/he has to take a print out of the submitted form and it has to be submitted physically to the Head of the Institution attaching all necessary documents like Birth Proof, Blood Group, Aadhar Card, Income Certificate and any other documents that are required to substantiate the inclusion of beneficiary.

After receiving both soft and hard copy (attached with other instruments), Operator will check it carefully. If s/he detects any error, s/he will modify it. Then Operator will forward it to Recommending Authority. The Recommending Authority will check it again. S/he can modify mistakes or can return it to Operators. Then the Recommending Authority will forward the application to the Head of the Institution for necessary approval. Finally Head of the Institution will approve the application if s/he finds it correct with his/her registered class 2/3 Digital Signature Certificate (DSC).

After getting message from WBHS portal, incumbent will take print out of approved enrolment certificate from WBHS portal after creating his/her individual login. No one except Head of the Institution can approve his/her own enrolment certificate.

(c) The enrolment of existing Teachers/Officers under the Scheme shall be completed within one year from the date of issue of the Notification.

(d) The Administrative Department has no role in enrolment procedure.

(e) On successful enrolment under the health scheme, the drawl of regular medical allowance shall be discontinued with effect from the 1 st day of the month following the month in which the certificate is issued.

8. Criteria for Reimbursement of Claims:

a. Enrolled teachers /officers will get the facility of OPD/IPD medical treatment in Govt. Hospitals, Hospitals managed by local bodies like municipalities, State-Aided Hospitals, Speciality/Enlisted Hospitals outside the state and Empanelled Private Hospitals as listed in Finance Department's Notification No. 3473-F dt. 11.05.09, and as amended from time to time. List of such HCOs will be available in the WBHS Portal.

b. The beneficiaries under this health scheme may also avail the only indoor medical treatment facilities in any non-empanelled private hospital/nursing home. Reimbursement of the cost of such indoor medical treatment is admissible under this scheme as per orders issued by Finance Department, Govt. of West Bengal.

c. For availing treatment in enlisted hospitals outside West Bengal, notification of Finance Department, Govt. of West Bengal shall be adhered strictly in this regard.

9. Accommodation/Entitlement:

a. In the case of medical attendance and treatments as an indoor patient in a Pay Bed of Govt. Hospital or Tata Medical Center, Rajarhat or Other Private Empanelled Hospital, a teacher/officer or his/her beneficiary shall be entitled to avail

the following accommodation as tabled below:

Sl. No.	Category of Beneficiary	Basic Pay/Salary Range as per ROPA-2019	Type of Accommodation
1	I	Rs.1,50,000/- & More.	i) **Pay Bed in Govt. Hospitals :** Single Occupancy Large Cabin ii) **Tata Medical Center, Rajarhat :** Private Bed iii) **Other Private Empanelled HCOs:** Private Room/ Private Cabin /Private Bed.
2	II	Rs. 75,000/- & more but less than Rs. 1,50,000/-	i) **Pay Bed in Govt. Hospitals:** Single Occupancy Small Cabin ii) **Tata Medical Center, Rajarhat :** General Bed iii) **Other Private Empanelled HCOs:** Private Room/ Private Cabin /Private Bed
3	III	Rs. 57,700/- & more but less than Rs. 75,000/-	i) **Pay Bed in Govt. Hospitals:** Double Occupancy Large Cabin ii) **Tata Medical Center, Rajarhat :** General Bed iii) **Other Private Empanelled HCOs:** Semi-Private Bed

10. Financial Power of sanctioning claim:

Financial power for sanctioning the cost of medical attendance and treatment for IPD and OPD treatment is given below:

Approving Authority	Financial Power	
	Indoor Treatment	O P D
Head of the Administrative Department for both College & University.	Full Power	

Delegated Approver of the Head of the Administrative Department.	Rs. 1.00 Lakh	Rs. 10,000/-

11. Settlement of Reimbursement Claims:

i. Enrolled Teacher/Officer will submit reimbursement claim using his/her individual login through West Bengal Health Scheme Portal. After online submission, she /he has to take a print out of submitted form and it has to be submitted physically to Head of Institution attaching all necessary documents like money receipts, annexure, all treatment documents and any other instruments that are required to substantiate the claim.

ii. After receiving both hard and soft copy (attached with other instruments), Operator will check it carefully. If she /he detects any error, she /he will modify it. Then Operator will forward it to Recommending Authority. The Recommending Authority will check it again. She /he can modify mistakes or can return it to Operators. The Recommending Authority will forward the correct application to the Head of Institution. Head of Institution will forward the claim to Administrative Department for necessary approval.

iii. On receiving both soft and hard copy of reimbursement claim, The Verifying Authority of the Administrative Department will check it again. Once she /he finds the claim in correct way, she /he will forward it to the Delegated Approver of the Administrative Department.

iv. On checking the claim, if the admissible amount is within the ceiling of Delegated Approver of the Administrative Department, she/he will approve it and generate sanction order with his/her registered Digital Signature Certificate (DSC). Delegated Approver of the Administrative Department will forward the claim to Head of the Department for approval if the admissible amount exceeds the ceiling delegated to him/her.

v. Head of the Department will approve the claims those are forwarded by the Delegated Approver of the Administrative Department. Registration of DSC by Head of the Department is not mandatory. She / he can approve the claim with his/her registered DSC. After approval of the claim amount by Department, DDO wise fund shall be allotted through e-bantan Module of IFMS in favour of DDO/Head of the Institution for the respective claimant.

vi. In all sanctioned claims, Administrative Department shall make necessary arrangement of stamping of " **Paid and Cancelled"** and signature by competent authority in all vouchers of such claim to the Institution.

vii. Once the sanction is accorded by the Department, there is no need for further sanction of the same by the institution as the case may be.

viii. After getting, sanction order and vouchers from competent authority, Operator of University/Department will prepare **Treasury Bill** in TR-31 in WBHS Portal and forward it to DDO for subsequent submission in WBIFMS (E-Billing module). Again DDO has to submit the said **Treasury Bill** using his registered DSC to linked Pay &Accounts office/ Treasury accessing his/her login in WBIFMS Portal without attaching any vouchers and beneficiary list.

ix. No physical voucher is required to be attached at the time of submission of bill to Treasury as per existing provision. All vouchers shall be preserved in College/ University for the purpose of future audit. Only sanction order shall be attached with **Treasury Bill** in TR Form 31 at the time of drawl of claim to Pay and Accounts Officer/Treasury.

x. Moreover, for settling a claim, notification no. 3474-F dt. 11.05.2009, 796-F(MED) dated 31.01.2011, 797-F(MED) dated 31.01.2011, 11253-F(MED) dated 16.11.2011, 796-F(MED) dated 19.09.2013 and other related order issued by Finance Department, Govt. of West Bengal shall be adhered strictly.

xi. List of inadmissible items, viz. Foods, Tonics, Medicines etc shall be guided as per Finance Department (Medical Cell) Memorandum No. 6586-F(MED) dated 29.06.2011 as amended from time to time by Finance Department of this Government.

The Forms of enrolment & reimbursement of claims along with the prescribed format for approval, recommendation and sanctioned of claim are annexed hereto.

Sl. No.	Form No.	Subject
1	Form -A	Application of Enrolment
2	Form-B	Certificate of Enrolment
3	Claim Forms	AG GIA Form C1 to C5
4	Form-R	Format of Sanction Order
5	Annexure-I	Essentiality Certificate for claiming OPD Reimbursement
6	Annexure-II	Essentiality Certificate for claiming IPD Reimbursement for availing treatment on Non-Empanelled Hospital or Institution
7		

12. Treatment in a hospital or institution outside the State:-

(i) Notwithstanding anything contained elsewhere in this scheme, the Government may recognize specialized hospitals and institute outside the State for treatment of specific diseases. All hospitals, situated outside West Bengal and notified by Finance Department, Govt. of West Bengal shall have to consider in this case. Treatment cost in case of availing treatment in a hospital outside West Bengal other than enlisted shall not be eligible for reimbursement.

(ii) Prior approval from Addl. Chief Secretary/Principal Secretary/Secretary of Agriculture Department shall be obtained for receiving medical attendance and treatment in these enlisted hospitals outside West Bengal. In case of technical opinion from doctor, Administrative Department may consult with West Bengal Health Scheme Authority (WBHSA) before final approval.

(iii) Claim for reimbursement of the cost of medical attendance and treatment in these hospitals shall be allowed on actual basis of various services provided by and investigations and procedures carried out by these hospitals only in the course of treatment.

(iv) Cost of inadmissible items mentioned in different notifications issued by Finance Department, Govt. of West Bengal is not allowed for reimbursement.

13. Operational Guidelines clarifications, etc. – (1) Agriculture Department in consultations with the Finance department (Medical Cell), wherever necessary, shall issue operational guidelines clarifications, etc. for implementation of the scheme.

(2) If any difficulty arises in the course of implementation of the scheme, it shall be referred to the Finance Department (Medical Cell) and the decision of the Finance Department (medical Cell) thereon shall be final.

(3) Further operational guidelines in this regard, if required, will be issued later on.

14. The Head of Account for allotment of fund for medical reimbursement: **"2415-01-277-010-31-02-V" under Demand No. 5 and Department Code "AG".**

15. The Annexure prescribing the Forms of Enrolment and Reimbursement of Claims will be available in the Website.

16. This Order is issued with the concurrence of Finance Department vide their U.O. No. E-399-F (Med), Dated: 01.06.2021.

17. All other concerned are being informed accordingly.

By order of the Governor

07/06/2021

Deputy Secretary to the
Govt. of West Bengal

No. 2080/1(18)-AG **Dated: 07.06.2021**

Copy forwarded for information and necessary action to:

1. Accountant General (A&E), West Bengal, Treasury Building, Kolkata -700001.
2. Principal Accountant General (Audit) West Bengal, Treasury Building Kolkata – 700001.
3. The Registrar, Bidhan Chandra Krishi Viswavidyalaya, Mohanpur, Dist.- Nadia.
4. The Registrar, Uttar Banga Krishi Viswavidyalaya, Pundibari, Dist.- Coochbehar.
5. The Comptroller, Bidhan Chandra Krishi Viswavidyalaya, Mohanpur, Dist.- Nadia.
6. The Comptroller, Uttar Banga Krishi Viswavidyalaya, Pundibari, Dist.- Coochbehar
7. The Finance Department (Medical Cell), Govt. of West Bengal.
8. The Finance (Budget) Department, Govt. of West Bengal.
9. The Director of Medical Education, Dept. of Health & Family Welfare, Govt. of West Bengal.
10. The Joint Secretary, Medical Education Branch, Dept. of Health & Family Welfare, Govt. of West Bengal.
11. The Deputy Secretary, Medical Education Branch, Dept. of Health & Family Welfare, Govt. of West Bengal.
12. The Treasury Officer, Kalyani Treasury, P.O.- Kalyani, Dist.- Nadia.
13. The Treasury Officer, Coochbehar, P.O. & Dist.- Coochbehar.
14. The PS to Hon'ble CM & MIC., Dept. of Health & Family Welfare &Department of Agriculture Govt. of West Bengal.
15. The PA to Hon'ble MOS., Dept. of Health & Family Welfare, Govt. of West Bengal.
16. The PA to the Addl. Chief Secretary/ Pr. Secretary/ Secretary of Agriculture Department & Health and Family Welfare Department.
17. The P.A. to the Vice-Chancellor of BCKV/ UBKV.
18. Guard File.

07/06/2021

Deputy Secretary to the
Govt. of West Bengal

FORM A
Application for Enrollment

To
The..... (Designation of the Head of Institution)
..... (Name of the Institution)
..... (Office Address of the Head of Institution)

I, Sri/Smt/Miss ..... (Name of the Teacher/Officer) ..... (Designation) do hereby opt for coming under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal with effect from.....

The particulars of me are stated herein under:

Sl. No.	Particulars	Details
1	Name of the Teacher/Officer	
2	Application ID	
3	Designation	
4	Gender	
5	Marital Status	
6	Residential Address	
7	Date of Birth	
8	Date of Entry into the University	
9	Date of Superannuation	
10	Rationalised Entry Pay	
11	DDO Code of the Head of Institution	
12	Mobile No.	
13	E-Mail Address	
14	Voter Card/ PAN/Aadhar No.	
15	Bank details for claim disbursement	

Details of eligible members of the family including me are given below:

Sl. No.	Name	Bate of Birth	Relation	Beneficiary ID	Blood Group	Photo	Signature

I do hereby declare that upon enrollment under the above scheme, I shall forgo the regular Medical Allowance drawn by me as a part of salary and abide by the provisions of the scheme issued by competent authority.

Enclo: *Copy of Pay slip, copy Identity & blood group proof of all beneficiaries and declaration of income of all eligible beneficiaries.*

Signature of Teacher/Officer:
Designation:

FORM-B

DEPARTMENT OF AGRICULTURE
BIDHAN CHANDRA KRISHI VISWAVIDYALAYA
Mohanpur, Dist.- Nadia, PIN- 741252
West Bengal

Certificate for Enrollment under WBHS for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal
Reimbursement Only

Memo No. **Date:**

Information of Teacher/ Officer					
1.	Name (In Block Letter)		2.	Enrollment ID.	
3.	Designation of the Teacher/ Officer		4.	Date of Entry into College/University	
5.	Address of the Teacher/ Officer		6.	Date of Superannuation	

Hospital Accommodation Entitlement		
1.	Pay Bed in Government Hospital run by Govt. of West Bengal	
2.	Tata Medical Center, Rajarhat	
3.	Other Private Empanelled HCOs	

Information of Beneficiaries (Including Teacher/Officer)					
1.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f.: Mobile No. : Email : Aadhaar No. :	Space for Signature
2.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f. : Mobile No. : Email : Aadhaar No. :	Space for Signature
3.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f. : Mobile No. : Email : Aadhaar No. :	Space for Signature

4.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f. : Mobile No. : Email : Aadhaar No. :	Space for Signature

List of Beneficiary with Critical Diseases (If Any)

Beneficiary Name	Beneficiary ID	Valid Upto	Certificate valid for Disease

Certified that above mentioned Teacher/Officer has been enrolled under the WBHS for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal along with above mentioned members of the family to get medical treatment under the scheme.

Name (Block Letter) :	
Designation :	

Digitally Signed. Does not require any Ink Signature.

DEPARTMENT OF AGRICULTURE
UTTAR BANGA KRISHI VISWAVIDYALAYA
Pundibari, Dist.- Coochbehar, PIN-
736165 West Bengal

Certificate for Enrollment under WBHS for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal
Reimbursement Only

Memo No. **Date:**

Information of Teacher/ Officer

1.	Name (In Block Letter)		2.	Enrollment ID.	
3.	Designation of the Teacher/ Officer		4.	Date of Entry into College/University	
5.	Address of the Teacher/ Officer		6.	Date of Superannuation	

Hospital Accommodation Entitlement

1.	Pay Bed in Government Hospital run by Govt. of West Bengal	
2.	Tata Medical Center, Rajarhat	
3.	Other Private Empanelled HCOs	

Information of Beneficiaries (Including Teacher/Officer)

1.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f.: Mobile No. : Email : Aadhaar No. :	Space for Signature
2.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f. : Mobile No. : Email : Aadhaar No. :	Space for Signature
3.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f. : Mobile No. : Email : Aadhaar No. :	Space for Signature
4.	Name of Beneficiary	Beneficiary ID : Relation With Academician/ Officer : Date of Birth : Blood Group :	Space for Photo	Enrollment w.e.f. : Mobile No. : Email : Aadhaar No. :	Space for Signature

List of Beneficiary with Critical Diseases (If Any)

Beneficiary Name	Beneficiary ID	**Valid Upto**	Certificate valid for Disease

Certified that above mentioned Teacher/Officer has been enrolled under the WBHS for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal along with above mentioned members of the family to get medical treatment under the scheme.

Name (Block Letter) :	
Designation :	

Digitally Signed. Does not require any Ink Signature.

CLAIM FORMS

Reimbursement for cost of Out-Door Patient (OPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where Teacher/Officer is attached)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs..... (Rupees.....) towards reimbursement of cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of Teacher/Officer.**			
Full Name (in Block letters)		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	
2. **Details of the Patient, Treating Hospital and Condonation Requirement, if any.**			

2.1	Name of the Patient		
2.2	Name of the Empanelled/Enlisted hospital where treatment was availed.		
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes	No Not known

3. **Details of Claimant** *(Applicable in case of death of employee)*		
Sl. No.	Name of the claimant	Relation
3.1		

4. **Permission Details, If any**		
Sl. No .	Permission sought	Details of permission approval
4.1	For treatment availed in enlisted hospital outside West Bengal *(see clause 12 of Order No.* Date).	Memo No. : Date: Designation / Authority : A. O. No. and date of Finance Deptt. West Bengal, if any:

Part-II [Details of Expenditure Statement of OPD treatment]

5. **Details of OPD Treatment**					
Sl. No.	**Particulars**	**Details**			
5.1	Category of OPD Claim (Tick mark in appropriate box) *[See list of diseases/illness mentioned in clause 6(1) and 6(2)]*	As per clause 6(1) of OPD List		As per clause 6(2) of OPD List	
5.2	Name of the OPD Disease/ Type of follow-up medical attendance and treatment				
5.3	Date of OPD consultation				

6. **Expenditure Statement of OPD treatment**				
Sl. No.	Name of Components			Amount Claimed (Rs.)
6.1	**Procedure Charges**			
	Sl. No. / Name of the Procedure	Procedure Code	Amount Admissible (Rs)	

6.2	**Consultation Fees**					
6.3	Cost of Pathological and Radiological Investigations					
	Sl. No.	Name of the Investigation	Coded / Non-Coded	Code of Investigation	Amount Admissible (Rs)	
6.4	**Cost of Medicines**					
	Period of medicine consumption		From		To	
6.5	**Cost of Implant / Special Device**					
	Sl. No.	Name of the Implant / Special Device	Code of Implant / Special Device	Amount Admissible (Rs)		
6.6	**Miscellaneous (specify)**					
					Total	
					No. of Vouchers	

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II minus Part III] or [Part-II minus Part-III plus Part IV]*	
Rs. :	In words: Rupees

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time

treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-I** duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital (***See notes of annexure-I carefully***).	Yes	No
2	Enrolment Certificate of beneficiary	Yes	No
3	Original Money Receipts in sequentially	Yes	No
4	Copy of OPD Prescription	Yes	No
5	Copy of permission granted if any	Yes	No
6	Original copy of Voucher/ Tax Invoice of Implants purchased	Yes	No
7	Copy of all investigation/ test reports in sequentially.	Yes	No
8	Essentiality supported with prescription and audiometric report from treating empanelled hospital/diagnostic centre ***(Applicable only for claiming reimbursement of Digital Hearing Aid).***	Yes	No
9	In case of death of Teacher/Officer; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes Yes Yes	 No No No
10	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes	No
11	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Reimbursement for cost of Out-Door Patient (OPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Generated by Teacher/Officer from WBHS Portal)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs..... (Rupees.....) towards reimbursement for cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below::

Part-I[General Information]

1. **Details of the Teacher/Officer.**				
Full Name			HRMS ID (If available)	
Enrollment ID No.			Claim Application ID.	
Bed Entitlement			Date of Enrolment	
2. **Details of Patient, Treating Hospital and Condonation Requirement, if any.**				
2.1	Name of the Patient			
	Beneficiary ID			
	Relationship with the Employee/Pensioner			
2.2	Name of the Empanelled/Enlisted hospital where treatment was availed.			
	Code of the Hospital			
	Class of Entitlement of the Hospital			
	Address of the Hospital			
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes	No	Not known

3. **Detail of Claimant** *(Applicable in case of death of employee)*		
Sl.No.	Name of the claimant	Relation
3.1		

4. **Permission Details, If any**		
Sl. No .	Permission sought	Details of permission approval
4.1	For treatment availed in enlisted hospital outside West Bengal *(see clause 12 of Order No. . Dated).*	Memo No. : Date : Designation / Authority : U.O. No. and date of Finance Deptt., West Bengal, if any:

Part-II [Details of Expenditure Statement of OPD treatment]

5. **Details of OPD Treatment**						
Sl. No.	**Particulars**	**Details**				
5.1	Category of OPD Claim (Tick mark in appropriate box) *[See list of diseases/illness mentioned in clause 6(1) and 6(2)]*	As per clause 6(1) of OPD List		As per clause 6(2) of OPD List		
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment					
5.3	Date of OPD consultation					

6. **Expenditure Statement of OPD treatment**									
Sl. No.	Name of Components								Amount Claimed (Rs.)
6.1	**Procedure Charges**								
	Sl. No.	Name of Procedure		Procedure Code		Amount Admissible (Rs)			
6.2	**Consultation Fees**								
6.3	Cost of Pathological and Radiological Investigations								
	Sl. No.	Name of Investigation	Coded / Non-Coded	Code of Investigation		Amount Admissible (Rs)			
6.4	**Cost of Medicines**								
	Period of medicine consumption		From		To				
6.5	**Cost of Implant / Special Device**								
	Sl. No.	Name of Implant / Special Device		Code of Implant / Special Device		Amount Admissible (Rs)			
6.6	**Miscellaneous (specify)**								
								Total	
								No. of vouchers	

Part-III [Medical Advance]

7. **Details of Medical Advance, if any**					
Name of the Treasury	DDO	Designation of	Treasury	Treasury	Amount (Rs.)

from where it was drawn	Code	DDO	Voucher No.	Voucher Date	

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II minus Part III] or [Part-II minus Part-III plus Part IV]*	
Rs. ;	In words; Rupees

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-I** duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital (***See notes of annexure-I carefully***).	Yes	No
2	Original Money Receipts in chronological dates	Yes	No
3	Copy of OPD Prescription	Yes	No
4	Copy of permission granted if any	Yes	No
5	Original copy of Voucher/ Tax Invoice of Implants purchased	Yes	No
6	Copy of all investigation/ test reports in sequentially.	Yes	No
7	Essentiality supported with prescription and audiometric report from treating empanelled hospital/diagnostic centre ***(Applicable only for claiming reimbursement of Digital Hearing Aid).***	Yes	No
8	In case of death of the Teacher/Officer; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes Yes Yes	No No No
9	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Reimbursement for cost of In-Patient Department (IPD) treatment in non-empanelled hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where the Teacher/Officer is attached)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs..... (Rupees.....) towards reimbursement of cost of In-Patient Department (IPD) treatment at non-empanelled hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. Details of the Teacher/Officer.			
Full Name (in Block letters)		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID *(To be filled at the time of online entry from end the Head of Office)*	

2. Detail of the Patient, Treating Hospital and Condonation Requirement, if any			
2.1	Name of the Patient		
2.2	Name of Non-Empanelled/hospital where treatment was availed.		
2.3	Requirement of approval of delay Condonation, if	Yes	No Not known

	Any(Tick mark in appropriate box)		

3. **Detail of Claimant** *(Applicable in case of death of employee)*		
Sl. No.	Name of the claimant	Relation
3.1		

Part-II [Details and Expenditure Statement of IPD treatment]

4. Period of treatment					
Admission Date			Discharge Date		
5. Type of Discharge					
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box
5.1	Normal		5.3	Referral	
5.2	Risk Bond		5.4	Death	

6. Amount Claimed for		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	
6.2	Only Non- Procedural/ Package Treatment	
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	

6.1 Details of Procedural/ Package Treatment				
Period of Procedural/ Package Treatment	From		To	
Sl. No	Name of Procedures/ Packages			Amount Claimed (Rs.)
6.1.1				
6.1.2				
6.1.3				
6.1.4				
6.1.5				
			Total	

6.2 Details of Implants Used		
Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment				
Period of Non-Procedural/ Package Treatment	From		To	
Sl. No.	Name of Components			Amount Claimed (Rs.)
6.3.1	Room/ Bed Rent			

	ICCU/ITU/ICU/NICU/PICU	From		To			
	HDU/SDU	From		To			
	Burn Unit	From		To			
	CRIB	From		To			
	General/Semi-Private/Private	From		To			
6.3.2	Consultation Fees						
6.3.3	Pathological and Radiological Investigations						
6.3.4	Medicines						
6.3.5	Consumables						
6.3.6	Special Nursing/Aya Charges						
6.3.7	Miscellaneous. (If Any Specify)						
						Total	
						No. of Vouchers	
						Total Treatment Cost [6.1+ 6.2+6.3]	

Part-III [Details of Discount and Insurance Coverage]

11. Details of Discount and Insurance Coverage, if any			
Sl. No.	Particulars	Amount (Rs.)	Remarks
1	Discount		
2	Insurance Coverage		

Net Claim: *(Part-II minus Part-III)*	
Rs. ;	In words; Rupees

Part-IV [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-II** duly signed with proper stamp by the Medical Superintendent / Administrative Officer of a Non-Empanelled Hospital	Yes	No
2	Enrolment Certificate of beneficiary	Yes	No
3	Bill Summary	Yes	No
4	Original Money Receipts in chronological dates	Yes	No

5	Copy of Discharge Summary (case summary and copy of death certificate in case of death) and OT note	Yes	No
6	Detailed Bill	Yes	No
7	Original copy of Voucher/ Tax Invoice of Implants used	Yes	No
8	Copy of all investigation/ test reports in sequentially	Yes	No
9	Copy of OT Note in case of procedural/package treatment and treatment summary or bed head ticket in case of non-procedural/package treatment	Yes	No
10	In case of death of the Teacher/Officer; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes Yes Yes	 No No No
11	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes	No
12	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Reimbursement for cost of In-Patient Department (IPD) treatment in non-empanelled hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Generated by the Teacher/Officer from WBHS Portal)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs..... (Rupees.....) towards reimbursement for cost of In-Patient Department (IPD) treatment at Non-Empanelled hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of the Teacher/Officer.**			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID	
Bed Entitlement		Date of Enrolment	

2. **Details of the Patient, Treating Hospital and Condonation Requirement, if any**			
2.1	Name of the Patient		
	Beneficiary ID		
	Relationship with the Teacher/Officer		
2.2	Name of the Non-Empanelled/hospital where treatment was availed.		
	Bed Capacity of Hospital		
	CE Licence No.		
	CE Licence valid up to		
	Address of Hospital		
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes	No / Not known

3. **Details of Claimant** *(Applicable in case of death of employee)*		
Sl.No.	Name of the claimant	Relation
3.1		

Part-II [Details of Expenditure Statement of IPD treatment]

4. **Period of treatment**					
Admission Date			Discharge date		
5. Type of Discharge					
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box
5.1	Normal		5.3	Referral	
5.2	Risk Bond		5.4	Death	

6. Amount Claimed for		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	
6.2	Only Non- Procedural/ Package Treatment	
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	

6.1 Details of Procedural/ Package Treatment			
	Period of Procedural/ Package Treatment	From	To
Sl. No	Name of Procedures/ Packages		Amount Claimed (Rs.)
6.1.1			
6.1.2			
6.1.3			

6.1.4		
6.1.5		
	Total	

6.2 Details of Implants Used		
Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment						
Period of Non-Procedural/ Package Treatment		From		To		
Sl. No.	Name of Components					Amount Claimed (Rs.)
6.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
6.3.2	Consultation Fees					
6.3.3	Pathological and Radiological Investigations					
6.3.4	Medicines					
6.3.5	Consumables					
6.3.6	Special Nursing/Aya Charges					
6.3.7	Miscellaneous. (If Any Specify)					
	Total					
	No. of Vouchers					
	Total Treatment Cost [6.1+ 6.2+6.3]					

Part-III [Details of Discount and Insurance Coverage]

11. Details of Discount and Insurance Coverage, if any			
Sl. No.	Particulars	Amount (Rs.)	Remarks
1	Discount		
2	Insurance Coverage		

Net Claim: *(Part-II minus Part-III)*	
Rs. ;	In words; Rupees

Part-IV [Declaration of the Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-II** duly signed with proper stamp by the Medical Superintendent / Administrative Officer of a Non-Empanelled Hospital	Yes	No
2	Bill Summary	Yes	No
3	Original Money Receipts in chronological dates	Yes	No
4	Copy of Discharge Summary (case summary and copy of death certificate in case of death) and OT note	Yes	No
5	Detailed Bill	Yes	No
6	Original copy of Voucher/ Tax Invoice of Implants used	Yes	No
7	Copy of all investigation/ test reports in sequentially	Yes	No
8	Copy of OT Note in case of procedural/package treatment and treatment summary or bed head ticket in case of non-procedural/package treatment	Yes	No
9	In case of death of the Teacher/Officer; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes Yes Yes	 No No No
10	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Reimbursement for cost of In-Patient Department (IPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where the Teacher/Officer is attached)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs..... (Rupees.....) towards reimbursement of cost of non-cashless In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of the Teacher/Officer.**			
Full Name *(in Block letters)*		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	
2. **Details of the Patient, Treating Hospital and Condonation Requirement, if any**			
2.1	Name of the Patient		

2.2	Name of the Empanelled/Enlisted hospital where treatment was availed			
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes	No	Not Known

3. **Details of the Claimant** *(applicable in case of death of employee)*

Sl. No.	Name of the claimant	Relation
3.1		

4. **Permission Details (If any)**

Sl. No .	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal [*see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]*	Permission ID : Permission approved for:
4.2	For treatment availed in enlisted hospital outside West Bengal *(see clause 12 of Order No. Dated)*	Memo No. : Date: Designation / Authority : U.O. No. and date of Finance Deptt. West Bengal, if any:

Part-II [Expenditure Statement of IPD treatment]

5. **Details of Treatment in Reimbursement Mode**

Period of treatment	Admission Date		Discharge date	

6. Type of Discharge

Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal		6.3	Referral	
6.2	Risk Bond		6.4	Death	

7.Amount Claimed for

Sl. No.	Type of Treatment	(Tick mark in appropriate box)
7.1	Only Procedural/ Package Treatment	
7.2	Only Non- Procedural/ Non-Package Treatment	
7.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment	

7.1 Details of Procedural/ Package Treatment

Period of Procedural/ Package Treatment	From		To	

Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount Claimed(Rs.)
7.1.1			
7.1.2			
7.1.3			
7.1.4			
7.1.5			
		Total	

7.2 Details of Implants Used

Sl.No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)
7.2.1				
7.2.2				
7.2.3				
7.2.4				
7.2.5				
			Total (Rs.)	

7.3 Details of Non-Procedural/ Non-Package Treatment.

Period of Non-Procedural/ Non-Package Treatment.		From		To		
Sl. No.	Name of Component					Amount Claimed (Rs.)
7.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
7.3.2	Consultation Fees.					
7.3.3	Pathological and Radiological Investigations.					
7.3.4	Medicines.					
7.3.5	Consumables					
7.3.6	Special Nursing/Aya Charges					
7.3.7	Miscellaneous. (If any specify)					
	Total Claim of Reimbursement Mode of Treatment(Rs.) (amount mentioned in 7.1+ 7.2+7.3)					
	No. of vouchers					

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

8. Indoor related OPD treatment		
Do you want to claim Indoor related OPD		

treatment cost i.e. cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes**	**No**

9. Details of Indoor related OPD Consultation

Dates	Nos. of Consultation

10. Details Expenditure of Indoor related OPD treatment

Sl. No.	Name of Components					Amount Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Investigations					
10.3	Cost of Medicines					
	Period of medicine consumption	From		To		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
	Nos. of vouchers					

Part-IV [Medical Advance]

11. Details of Medical Advance, if any

Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any

Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Part-VI [Details of Discount and Insurance Coverage]

13. Details of Discount and Insurance Coverage, if any

Sl. No.	Particulars	Amount (Rs.)	Remarks
1	Discount		
2	Insurance Coverage		

Net Claim: *[Part-II plus Part-III minus Part IV minus Part VI] or [Part-II plus Part-III minus Part IV plus V minus Part VI]*	
Rs. ;	In words; Rupees

Part-VII [Declaration of the Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrolment Certificate of beneficiary	Yes	No
2	Bill Summary of Indoor Treatment and OPD treatment	Yes	No
3	Original Money Receipts of both Indoor and OPD treatment in chronological dates	Yes	No
4	Copy of related OPD Prescriptions (if claimed)	Yes	No
5	Copy of Discharge Summary (case summary and copy of death certificate in case of death) and OT note	Yes	No
5	Copy of permission granted, if any	Yes	No
7	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011, if any	Yes	No
8	Copy of Detailed Bill of Indoor Treatment	Yes	No
9	Original copy of Voucher/ Tax Invoice of Implants used	Yes	No
10	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment sequentially	Yes	No
11	In case of death of Teacher/Officer; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes Yes Yes	No No No
12	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes	No
13	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Reimbursement for cost of In-Patient Department (IPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Generated by the Teacher/Officer from WBHS Portal)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs..... (Rupees.....) towards reimbursement for cost of non-cashless In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of the Teacher/Officer.**			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	

2. **Details of the Patient, Treating Hospital and Condonation Requirement, if any**		
2.1	Name of the Patient	
	Beneficiary ID	
	Relationship with the Teacher/Officer	
2.2	Name of the Empanelled/Enlisted hospital where treatment was availed.	
	Code of Hospital	

	Class of Entitlement of Hospital		
	Address of Hospital		
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes	No Not Known

3. **Details of Claimant** *(applicable in case of death of employee or pensioner or family pensioner)*

Sl. No.	Name of claimant	Relation
3.1		

4. **Permission Details (If any)**

Sl. No .	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal [*see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]*	Permission ID : Permission approved for:
4.2	For treatment availed in enlisted hospital outside West Bengal *(see clause 12 of Order No. Dated)*.	Memo No. : Date : Designation / Authority : U.O. No. and date of Finance Deptt. West Bengal, if any:

Part-II [Details of Expenditure Statement of IPD treatment]

5. **Details of Treatment in Reimbursement Mode**

Period of treatment	Admission Date		Discharge date	

6. Type of Discharge

Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal		6.3	Referral	
6.2	Risk Bond		6.4	Death	

7. Amount Claimed for

Sl. No.	Type of Treatment	(Tick mark in appropriate box)
7.1	Only Procedural/ Package Treatment	
7.2	Only Non- Procedural/ Non-Package Treatment	
7.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment	

7.1 Details of Procedural/ Package Treatment

Period of Procedural/ Package Treatment	From		To	

Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount Claimed(Rs.)
7.1.1			
7.1.2			
7.1.3			
7.1.4			
7.1.5			
		Total	

7.2 Details of Implants Used

Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)
7.2.1				
7.2.2				
7.2.3				
7.2.4				
7.2.5				
			Total (Rs.)	

7.3 Details of Non-Procedural/ Non-Package Treatment.

Period of Non-Procedural/ Non-Package Treatment.	From		To	

Sl. No.	Name of Components					Amount Claimed (Rs.)
7.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
7.3.2	Consultation Fees.					
7.3.3	Pathological and Radiological Investigations.					
7.3.4	Medicines.					
7.3.5	Consumables					
7.3.6	Special Nursing/Aya Charges					
7.3.7	Miscellaneous. (If any specify)					
	Total Claim of Reimbursement Mode of Treatment(Rs.) (amount mentioned in 7.1+ 7.2+7.3)					
	No. of vouchers					

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

8. Indoor related OPD treatment		
Do you want to claim Indoor related OPD		

treatment cost i.e cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes**	**No**

9. Details of Indoor related OPD Consultation

Dates	Nos. of Consultation

10. Details Expenditure of Indoor related OPD treatment

Sl. No.	Name of Components						Amount Claimed (Rs.)
10.1	Consultation Fees						
10.2	Cost of Pathological and Radiological Investigations						
10.3	Cost of Medicines						
	Period of medicine consumption	From		To			
10.4	Cost of Special Device						
10.5	Miscellaneous (specify)						
	Total claim of indoor related OPD(Rs.)						
	Nos. of vouchers						

Part-IV [Medical Advance]

11. Details of Medical Advance, if any

Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any

Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Part-VI [Details of Discount and Insurance Coverage]

13. Details of Discount and Insurance Coverage, if any

Sl. No.	Particulars	Amount (Rs.)	Remarks
1	Discount		
2	Insurance Coverage		

Net Claim: *[Part-II plus Part-III minus Part IV minus Part VI] or [Part-II plus Part-III minus Part IV plus V minus Part VI]*	
Rs. ;	In words; Rupees

Part-VII [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes	No
2	Money Receipts of both Indoor and OPD treatment sequentially	Yes	No
3	Original Money Receipts of both Indoor and OPD treatment in chronological dates	Yes	No
4	Copy of Discharge Summary (case summary and copy of death certificate in case of death) and OT note	Yes	No
5	Copy of permission granted if any.	Yes	No
6	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011, if any	Yes	No
7	Copy of Detailed Bill of Indoor Treatment	Yes	No
8	Original copy of Voucher/ Tax Invoice of Implants used	Yes	No
9	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment in sequence manner (In chronological order)	Yes	No
10	In case of death of the Teacher/Officer; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes Yes Yes	No No No
11	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

recognised/empanelled/enlisted hospital
for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of the Head of Institution where the Teacher/Officer is attached)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards **Advance** of cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of Teacher/Officer.**			
Full Name (in Block letters)		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. **Details of the Patient, Treating Hospital.**		
2.1	Name of the Patient	
2.2	Name of the Empanelled/Enlisted hospital from where estimate is received.	

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital		
3.1 No. of days for which hospital produced Estimated Expenditure		( ) Days
3.2 Details of OPD Diseases for which advance is sought		
Sl. No.	**Particulars**	**Name of diseases**
3.2.1	Name of OPD Diseases	Carcinoma

	for which advance is required(Tick mark in appropriate box)		BitaThallsaemia		*Hepatitis C*		*including Multiple Myeloma* is

4. Cost Component of OPD treatment as per estimate submitted by Empanelled/Enlisted hospital

Sl. No.	Name of Component	Nos.	Period		Amount (Rs.)
			From	To	
4.1	Consultation Fees				
4.2	Cost of Pathological and Radiological Investigations				
4.3	Cost of Medicines				
4.4	Cost of Implant / Special Device				
4.5	Miscellaneous (specify)				
				Total	

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance (80 % of total of sl. no. 4)	
2	Amount of Advance Applied for	

Amount of Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III]	
Rs:	
In words:	Rupees

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of the Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrolment Certificate of patient	Yes	No

2	Original Estimate issued by Empanelled/Enlisted hospital for seeking advance	Yes	No
3	Prognosis Report of patient issued by Treating Specialist	Yes	No
4	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only)	Yes	No
5	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

recognised/empanelled/enlisted hospital
for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Generated by the Teacher/Officer from WBHS Portal)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards advance for cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. Details of the Teacher/Officer.			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	
2. Details of the Patient, Treating Hospital			
2.1	Name of the Patient		
	Beneficiary ID		
	Relationship with the Teacher/Officer		

2.2	Name of the Empanelled/Enlisted hospital where treatment is availed.	
	Code of the Hospital	
	Class of Entitlement of Hospital	
	Address of the Hospital	

Part-II [Details of Cost Component of Estimate]

3. **Estimate of Hospital**							
3.1 No. of days for which hospital produced Estimated Expenditure			( ) Days				
3.2 Details of OPD Diseases for which advance is sought							
Sl. No.	**Particulars**	**Name of diseases**					
3.2.1	Name of OPD Diseases for which advance is required (Tick mark in appropriate box)		Bita Thallsaemia		*Hepatitis C*		*Carcinoma including Multiple Myeloma* is

4. **Cost Component of OPD treatment as per Estimate submitted by Empanelled/Enlisted hospital**

Sl. No.	Name of Component	Nos.	Period		Amount (Rs.)
			From	To	
4.1	Consultation Fees				
4.2	Cost of Pathological and Radiological Investigations				
4.3	Cost of Medicines				
4.4	Cost of Implant / Special Device				
4.5	Miscellaneous (specify)				
				Total	

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance (80 % of total of sl. no. 4)	
2	Amount of Advance Applied for	

Amount of Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III]

Rs:	
In words:	Rupees

Part-IV [Details of Advance Claimant]

Sl. No.	Name of the Claimant	Relation
1		

Part-V [Declaration of the Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Original Estimate issued by empanelled hospital for seeking advance	Yes	No
2	Prognosis Report of patient issued by Treating Specialist	Yes	No
3	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of the Head of Institution where the the Teacher/Officer is attached)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards **Advance** of cost of In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of the Teacher/Officer.**			
Full Name *(in Block letters)*		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. **Details of the Patient, Treating Hospital**					
2.1	Name of the Patient				
2.2	Name of the Empanelled/Enlisted hospital where treatment availed				

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital				
3.1 No. of days for which hospital produced Estimated Expenditure			**( ) days**	
3.2 Estimate cost of Procedural/ Package Treatment				
Sl. No.	Name of Procedures/ Packages		Procedure Code	Amount (Rs.)
3.2.1				
3.2.2				
3.2.3				
3.2.4				
3.2.5				
			Total	

3.3 Estimate cost of Implants Used				
Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount (Rs.)
3.3.1				
3.3.2				
3.3.3				
3.3.4				

3.3.5						
					Total (Rs.)	

3.4 Estimate cost of Non-Procedural/ Non-Package Treatment.

Sl. No.	Name of Component					Amount (Rs.)
3.4.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
3.4.2	Consultation Fees.					
3.4.3	Pathological and Radiological Investigations.					
3.4.4	Medicines.					
3.4.5	Consumables					
3.4.6	Special Nursing/Aya Charges					
3.4.7	Miscellaneous. (If any specify)					
	Amount of Total Estimate submitted by Hospital(Rs.) (amount mentioned in 3.2+ 3.3+3.4)					

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance 80 % of (3.2+ 3.3+3.4)	
2	Amount of Advance Applied for	

Amount of Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III]	
Rs.	
In words:	Rupees

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of the Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrolment Certificate of patient	Yes	No
2	Original Estimate issued by empanelled hospital for seeking advance	Yes	No
3	Prognosis Report of patient issued by Treating Specialist	Yes	No
4	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only)	Yes	No
5	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Agriculture Department, Govt. of West Bengal

(As per Order No. , Dated)

(Generated by the Teacher/Officer from WBHS Portal)

To
The ..... (Designation of HoI)
..... (Name of the Institution)
..... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....)
towards **Advance** of cost of In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital

under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal as per details stated below:

Part-I[General Information]

1. **Details of the Teacher/Officer.**			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	

2. **Details of the Patient, Treating Hospital**		
2.1	Name of the Patient	
	Beneficiary ID	
	Relationship with the Teacher/Officer	
2.2	Name of the Empanelled/Enlisted hospital where treatment availed	
	Code of the Hospital	
	Class of Entitlement of the Hospital	
	Address of Hospital	

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital			
3.1 No. of days for which hospital produced Estimated Expenditure			**( ) days**
3.2 Estimate cost of Procedural / Package Treatment			
Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount (Rs.)
3.2.1			
3.2.2			
3.2.3			
3.2.4			
3.2.5			
		Total	

3.3 Estimate cost of Implants Used				
Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount (Rs.)
3.3.1				
3.3.2				
3.3.3				

3.3.4				
3.3.5				
			Total (Rs.)	

3.4 Estimate cost of Non-Procedural/ Non-Package Treatment.

Sl. No.	Name of Component					Amount (Rs.)
3.4.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From		To		
	HDU/SDU	From		To		
	Burn Unit	From		To		
	CRIB	From		To		
	General/Semi-Private/Private	From		To		
3.4.2	Consultation Fees.					
3.4.3	Pathological and Radiological Investigations.					
3.4.4	Medicines.					
3.4.5	Consumables					
3.4.6	Special Nursing/Aya Charges					
3.4.7	Miscellaneous. (If any specify)					
	Amount of Total Estimate submitted by Hospital(Rs.) (amount mentioned in 3.2+ 3.3+.4)					

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance 80 % of (3.2+ 3.3+3.4)	
2	Amount of Advance Applied for	

Amount of Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III]	
Rs.	
In words:	Rupees

Part-IV [Details of Advance Claimant]

Sl. No.	Name of the Claimant	Relation
1		

Part-V [Declaration of the Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time

treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Original Estimate issued by empanelled hospital for seeking advance	Yes	No
2	Prognosis Report of patient issued by Treating Specialist	Yes	No
3	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

OPD List

5.2	Name of the OPD Disease/ Type of follow-up medical attendance and treatment					
5.3	Date of OPD consultation					

6. Expenditure Statement of OPD treatment

Sl. No.	Name of Components					Amount Claimed (Rs.)
6.1	**Procedure Charges**					
	Sl. No.	Name of the Procedure	Procedure Code	Amount Admissible (Rs)		
6.2	**Consultation Fees**					
6.3	Cost of Pathological and Radiological Investigations					
	Sl. No.	Name of the Investigation	Coded / Non-Coded	Code of Investigation	Amount	

					Admissible (Rs)	
6.4	**Cost of Medicines**					
	Period of medicine consumption	From		To		
6.5	**Cost of Implant / Special Device**					
	Sl. No.	Name of the Implant / Special Device	Code of Implant / Special Device	Amount Admissible (Rs)		
6.6	**Miscellaneous (specify)**					
					Total	
					No. of Vouchers	

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of the Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II minus Part III] or [Part-II minus Part-III plus Part IV]*	
Rs. :	In words: Rupees

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief . The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of .....Rules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-I** duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital (***See notes of annexure-I carefully***).	Yes	No
2	Enrolment Certificate of beneficiary	Yes	No
3	Original Money Receipts in sequentially	Yes	No
4	Copy of OPD Prescription	Yes	No
5	Copy of permission granted if any	Yes	No
6	Original copy of Voucher/ Tax Invoice of Implants purchased	Yes	No
7	Copy of all investigation/ test reports in sequentially.	Yes	No
8	Essentiality supported with prescription and audiometric report from treating empanelled hospital/diagnostic centre ***(Applicable only for claiming reimbursement of Digital Hearing Aid).***	Yes	No
9	In case of death of Teacher/Officer; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes Yes Yes	No No No
10	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes	No
11	Any other instruments (Specify)	Yes	No

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

CLAIM ID:

Government of West Bengal
Department of Agriculture
Education Branch
Block- III, 2 nd Floor,
Writers' Buildings, Kolkata- 700001

No : **Dated :**

To

1. The Principal Account General (A & E), West Bengal, Treasury Building, Kol-1.
2. Pay and Accounts Officer/Treasury Officer, ...(Name of PAO/Treasury),

Address ofName of PAO/Treasury

Sub:- Sanction order for Reimbursement of Medical Expenditure of ..... (Name of the Teacher/Officer) ..... (Designation) under West Bengal Health Scheme for the Beneficiaries of Grant – In – Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal.

Sl. No.	Particulars	Details
1	Enrollment ID. of the Teacher/Officer	
2	Name of the Teacher/Officer	
3	Name of the Patient	
4	Beneficiary ID of the Patient	
5	Relationship with the Teacher/Officer	
6	Designation of the Head of Institution	
7	DDO Code of the Drawing & Disbursing Officer	
8	Designation of the Drawing & Disbursing Officer	
9	Head of Account	**"2415-01-277-010-31-02-V" under Demand No. 5 and Department Code "AG".**
10	Type of Treatment	
11	Name of the Hospital where treatment availed	
12	Type of the Hospital	
13	Amount Claimed (Rs.)	
14	Amount Sanctioned in figure (Rs.)	
15	Amount Sanctioned in words (Rupees)	
16	Name of the Claimant (In case of death) and Relation	NA

All others concerned are being requested to access WBHS portal using your login for verification and necessary action.

Digitally Signed. Does not require any Ink Signature.

Annexure-I

Certification of Treating Specialist/Consultant of **Recognised/Empanelled/Enlisted** Hospital for claiming reimbursement of **"Out Patient Department(OPD)"** treatment under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal.

1. Certified that the Patient, Sri/Smt._____, having Beneficiary ID _____ is a beneficiary of the scheme stated above.
2. She/he has been suffering from _____(specify name of the disease) as listed in Sl. No.____ of the OPD list as per 6(1) clause or follow-up medical attendance and treatment of _____ as per 6(2) clause of Order No. ..... dt ..... issued by Agriculture Department, Govt. of West Bengal.
3. Date of consultation is _____ .

Date:
Signature of Treating Specialist/Consultant:
Registration No. and Authority:
Name of Hospital :
Official Seal of the Hospital:

List of OPD (Out Patient Department) Diseases

As per clause 6(1) of.....				As per clause 6 (2) of	
Sl. No	**Name of the Disease**	**Sl. No**	**Name of Disease**	**Sl. No**	**Name of the Disease**
1	Malignant Diseases.	10	Injuries Caused by Accident (including Animal Bite).	1	Neuro Surgery.
2	Tuberculosis.	11	Rheumatoid Arthritis.	2	Cardiac Surgery (Including Coronary Angioplasty and implants).
3	Hepatitis B/C and Other Liver Diseases.	12	Systematic Lupus Erytthematous (LUPUS).	3	Cancer Surgery/ Chemotherapy/ Radiotherapy.
4	Insulin Dependent Diabetes (Type-2 Diabetic Mellitus is not considered as Insulin Dependent Diabetes).	13	Crohn's Disease.	4	Renal Transplant.
5	Heart Diseases.	14	Endodontic Treatment (Root Canal Treatment).	5	Hip/ Knee replacement Surgery.
6	Neurological Disorder/ Cerebra Vascular Disorders.	15	COPD (Chronic Obstructive Pulmonary Disease).	6	Accident cases.
7	Malignant Malaria.	16	Ankylosing Spondylitis		
8	Renal Failure.	17	None of the above list [Vide para 10 of 797-F(MED), dated 31.01.2011]		
9	Thallasaemia/ Bleeding orders/ Platelet Disorders.				

***** In case of OPD treatment, where medicine is prescribed for indefinite period, Employee/Pensioner/Family Pensioner can submit his/her successive reimbursement claim with copy of this annexure only once.***

Annexure-II

Certification of Medical Superintendent/Administrative Officer of treating **Non-Empanelled Hospital** for claiming reimbursement of only **"Indoor"** treatment under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Agriculture Department, Govt. of West Bengal

1. Certified that the Patient, Sri/Smt._____,
   having Beneficiary ID _____ is a beneficiary of

the scheme stated above and s/he availed an indoor treatment for period from _____ to _____.

2. Certified that the Hospital/Nursing Home/Health Care Organisation has _____ ( ) nos. of bed.
3. Certified that the Hospital/Nursing Home/Health Care Organisation obtained a License under the West Bengal Clinical Establishment Act and Rules bearing no. _____ and this License is valid up to _____.

Date:
Signature of Superintendent/Administrative Officer :

Name of Hospital:

Official Seal of the Hospital: