Government of West Bengal Finance Department Medical Cell

No.: 78-F(MED)WB

Dated : 22/10/2019

MEMORANDUM

Sub : Introduction of revised "Reimbursement Claim Forms" of West Bengal Health Scheme

Employees / Pensioners / Family Pensioners submit their reimbursement claim under West Bengal Health Scheme in the specified forms circulated vide order no. 6953-F(MED), dated; 11.07.2011 attaching essential documents required for such reimbursement.

West Bengal Health Scheme Portal has been upgraded and various services and process have been made online. Now various applications by employees / pensioners and family pensioners can be made online and Heads of Offices and DDOs can perform various functions, processing and approval online.

"Application Forms" have been modified to make them simpler and compatible with online mode.

After careful observation, the Governor is pleased to abolish all the existing forms and introduce **revised physical Application Forms** and also introduce **online reimbursement claim forms** of each category of the following:

- i. Form-C1 [Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital].
- ii. **Form-C2** [Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital].
- iii. **Form-C3** [Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital].
- iv. Form-C4 [Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital].

An Employees / Pensioner / Family Pensioner have to now submit the claim for reimbursement of expenditure incurred for treatment under WBHS in these revised forms only.

This order shall come into effect from the date of issue of this order.

Enclosures : As stated

(Parwez Ahmad Siddiqui) Secretary Finance Department

Form -C1

Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

under West Bengal Health Scheme

<u>(Applicable for those who are not able to claim through online by himself/herself and online entry shall</u> have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner.								
Full Nam	е			HRMS ID / PPO No.				
(in Block	letters)							
Enrollme	nt ID No.			C	laim Applicatio	on ID.		
					o be filled at			
					nline entry fro	-		
					f Head of Offic			
2. D	2. Details of Patient, Treating Hospital and Condonation Requirement, if any.							
2.1	Name of Patier	nt						
2.2	Name of Empa	nelled/Enlisted hospital	l where					
	treatment was	eatment was availed.						
2.3	Requirement	of approval of delay (Condonatior	٦,	Yes 🗆	No□	Not known□	
	if any(Tick mar	k in appropriate box)						
3. D	etails of Claim	ant (Applicable in cas	se of death	of e	mployee or pe	ensioner or j	family pensioner)	
SI. No.		Name of claimant	Relation			ion		
3.1								
4. P	ermission Det	ails, If any						
SI. No.	Perm	ission sought	De	tails	s of permissio	n approval		
4.1	For treatmer	t availed in enlisted	Memo No.					
	hospital out	tside West Bengal	Date:					
	(see clause 1	4 of order no.7287,	Designatio	n /	Authority :			
	dated 19.09.		U.O. No. a		-			
			Finance De	eptt	. West Benga	l, if any:		

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

5. C	5. Details of OPD Treatment								
SI. No.	Particulars	Details							
5.1	Category of OPD Claim (Tick mark in appropriate box)[See list of diseases/illness mentioned in clause 7(1) and 7(2)]			As per claus of OPD List	e 7(2)				
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment								
5.3	Date of OPD consultation								
6. E	6. Expenditure Statement of OPD treatment								
SI.	Name of Components Amount								

No.	0.						
6.1 Consultation Fees							
6.2 Cost of Pathological and Radiological Investigations							
6.3	Cost of Medicines						
	Period of medicine consumption	From		То			
6.4	4 Cost of Special Device						
6.5	5 Miscellaneous (specify)						
Total							
No. of Vouchers							

Part-III [Medical Advance]

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

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any							
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount		
where it was drawn	Code		Challan No.	Challan Date	(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 Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

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	Yes 🗆	No 🗆	
2	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆	
3	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/ Challan of Implants	Yes 🗆	No 🗆	
7	Copy of all investigation/ test reports in sequentially.	Yes 🗆	No 🗆	

8	In case of death of Employee, Pensioner and Family Pensioner;		
	a. An, affidavit on stamp paper by claimant	Yes 🗆	No 🗖
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No 🗆
	c. Copy of death certificate	Yes 🗆	No 🗆
9	Filled ECS mandate form in case of those, whose bank details is not		
	available in IFMS (in case of first claim only)	Yes 🗆	No 🗆
10	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant:				
Name in Block Letters	:			
Designation/Last Designation	:			

Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital

under West Bengal Health Scheme

(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 Office)

Part-I[General Information]

1.	1. Details of Employee/Pensioner.							
Full Name		HRMS ID / PPO No.						
(in Blo	ck letters)							
Enrolln	nent ID No.		Claim	Application	ID			
			(To b	e filled at the	time of			
			onlin	e entry from e	end the			
			Head	of Office)				
2.	Detail of Patient	, Treating Hospital and Condon	ation	Requirement	t, if any			
2.1	Name of Patient							
2.2	Name of Non-En	npanelled/hospital where treatr	nent					
	was availed.							
2.3	Requirement of	approval of delay Condonation,	if	Yes 🗆	No□	Not known□		
	Any (Tick mark in	appropriate box)						
3.	3. Detail of Claimant (Applicable in case of death of employee or pensioner or family pensioner)							
SI. No.		Name of claimant		Relation				
3.1								

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

4. Per	4. Period of treatment						
	Admission Date			Discharge Date			
5. Тур	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. Am	nount Claimed for						
SI. No.		Tick mark in appropriate box					
6.1	Only Procedural/ Packa						
6.2	Only Non- Procedural/						
6.3	Both Procedural/ Packa	ige and Non- Procedu	ural/ Packa	ge Treatment			
6.1 Det	ails of Procedural/ Pack	age Treatment					
	Period of Procedural/ Pa	ackage Treatment	From		То		
SI. 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 Det	ails of Implants Used					
Sl. No.	Nam	e of Implants			Amo	unt Claimed
						(Rs.)
6.2.1						
6.2.2						
6.2.3						
6.2.4						
				Total		
	ills of Non-Procedural/ Package T				-	
-	f Non-Procedural/ Package Treat		From		То	
SI. No.	Name	of Componen	ts		Amo	unt Claimed (Rs.)
6.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From	То			
	HDU/SDU	From	То			
	Burn Unit	From	То			
	CRIB	From	То			
	General/Semi-Private/Private	From	То			
6.3.2	Consultation Fees		I			
6.3.3	Pathological and Radiological Inv	vestigations				
6.3.4	Medicines					
6.3.5	6.3.5 Consumables					
6.3.6	5.3.6 Special Nursing/Aya Charges					
6.3.7 Miscellaneous. (If Any Specify)						
				Total		
			N	o. of Vouchers		
		Total Tr	eatment Cost	[6.1+ 6.2+6.3]		

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

Part-III [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

SI.	Name/Particulars of enclosures to be attached	Enclosed or not
-----	---	-----------------

No.			
1	Annexure-II duly signed with proper stamp by the Medical	Yes 🗆	No 🗆
	Superintendent of a Non-Empanelled Hospital		
2	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆
3	Bill Summary	Yes 🗆	No 🗆
4	Money Receipts in sequentially	Yes 🗆	No 🗆
5	Copy of Discharge Summary (Case summary in case of death) and OT note and copy of death certificate	Yes 🗆	No 🗆
6	Detailed Bill	Yes 🗆	No 🗆
7	Original copy of Voucher/ Tax Invoice/ Challan of Implants	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	Yes 🗆	No 🗆
	treatment summary or bed head ticket in case of non- procedural/package treatment		
10	In case of death of Employee, Pensioner and Family Pensioner;		
	a. An affidavit on stamp paper by claimant	Yes 🗆	No□
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No□
	c. Copy of death certificate	Yes 🗆	No□
11	Filled ECS mandate form in case of those, whose bank details is not	Yes 🗆	No 🗆
	available in IFMS (in case of first claim only)		
12	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant:

Name in Block Letters	:
Designation/Last Designation	:

Form –C3

Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital

under West Bengal Health Scheme

(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 Office)

Part-I[General Information]

1. D	1. Details of Employee/Pensioner						
Full Na	ame			HR	MS ID	/ PPO No.	
(in Block	eletters)						
Enrolli	ment ID No.					plication ID.	
					-	at the time of	
					ine entry ad of Offi	from the end of ce)	
2. D	etails of Patie	nt, Treating Hospital and Co	ndona	ation Requirem	nent, if	any	
2.1	Name of Pati	ent					
2.2	Name of Emp	panelled/Enlisted hospital					
	where treatment was availed						
2.3	Requirement	of approval of delay	Yes	5 🗆	No□	N	ot known□
	Condonation	, if any (Mark in appropriate					
	box)	-					
3. D	etails of Claim	nant (applicable in case of dea	ath of	^{employee} or p	ension	er or family pe	ensioner)
SI. No		Name of claima	nt			Rel	ation
3.1							
4. P	ermission Det	ails (If any)					
SI. No. Permission sought				Deta	ails of p	permission app	proval
4.1	For treat	ment availed in empane	anelled Permission ID :				
	private h	ospital within West Benga	al[see	Permission app	proved	for:	
		of Order No. 796 and 797,					
		11253-F(MED), dated; 16.12.2013	l and				
	7578-F(MED) dated;04.09.2012]					

Part-II [Expenditure Statement of IPD treatment]

5. Detai	5. Details of Treatment in Cashless Mode							
Sl. No.	Particulars			Details				
5.1	Transaction ID of Cashless	Treatment						
	(See Form-H or D4 supplied by h	ospital at the time of a	lischarge)					
5.2	Treatment Period	Admission Date		Discharge Date				
5.3	Total Treatment Cost (Rs.)							
5.4	Cashless Admissible Reimbur	sement Certificate (CARC)No.					
5.5	Amount paid to hospital (R	ks.)						
5.6	Amount admissible for reir	nbursement agains	st CARC(Rs.)					
	(See Row no. 16 of CARC ge	enerated through s	ystem)					
	Total Claim of I	ndoor Cashless Tre	eatment (Rs.)					
		(amount mei	ntioned in 5.6)					
	Total no	s. of Vouchers/Mo	ney Receipts					

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

	rare in [Details of Expenditure statement of indoor related of D treatment]						
6.	. Indoor related OPD treatment						
	Do you want to claim Indoor related OPD treatment						

Manual/Offline Reimbursement Claim Form

a	ost i.e cost of OPD treatment 30 days dmission and 30 days after discharge? (Tick opropriate box)	-	Yes 🗆			No□
7. De	etails of Indoor related OPD Consultation					
	Dates		Ν	os. of	Consultation	
8. De	etails of Indoor related OPD treatment Exp	enditure	:			
SI.	Name of Con	ponents	5			Amount
No.						Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Inve	stigation	S			
8.3	Cost of Medicines					
	Period of medicine consumption	From		То		
8.4	Cost of Special Devices					
8.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
				Nos.	of Vouchers	

Part-IV [Medical Advance]

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

Part-V [Refund of Medical Advance]

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

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

Part-VI [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Manual/Offline Reimbursement Claim Form

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆
2	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes 🗆	No 🗆
3	Money Receipts of both Indoor and OPD treatment sequentially	Yes 🗆	No 🗆
4	Copy of related OPD Prescriptions sequentially (if claimed)	Yes 🗆	No 🗆
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes 🗆	No 🗆
6	Copy of Form-H	Yes 🗆	No 🗆
7	Copy of Form-D4	Yes 🗆	No口
8	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes 🗆	No口
9	 In case of death of Employee, Pensioner and Family Pensioner; 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 Employee/Pensioner/Claimant	:
Name in Block Letters	:
Designation/Last Designation	:

Form –C4

Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital

under West Bengal Health Scheme

(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 Office)

Part-I[General Information]

1. Det	1. Details of Employee/Pensioner						
Full Nar	me				HRMS ID	/ PPO No.	
(in Block le	etters)						
Enrollm	ient ID No.					plication ID.	
						at the time of	
					Head of Off	from the end of ice)	
2. Det	tails of Patie	nt, Treating Hosp	oital and Con	donation Requ	irement, i	fany	
2.1	Name of Pati	ent					
2.2	Name of Emp	oanelled/Enlisted	hospital				
۱ I I	where treatn	nent was availed					
2.3 F	Requirement	of approval	of delay	Yes 🗆	No 🗆	Not kno	own 🗆
	Condonation,	, ,	mark in				
ā	appropriate b)x)					
3. Det	tails of Claim	ant (applicable ii	n case of dea	th of employee	or pensior	ner or family p	ensioner)
SI. No.		Nan	ne of claiman	it		Re	lation
3.1							
4. Per	rmission Det	ails (If any)					
SI. No.	Per	mission sought		Details of permission approval			
4.1	For treatn	nent availed in	empanelled	Permission ID	:		
		spital within Wes	• •	Permission app	proved for:		
		f Order No. 796 ar					
		11253-F(MED), date					
4.2		<i>MED) dated;04.09.20</i> ment availed	in enlisted	Memo No.			
4.2						•	
hospital outside West Bengal (see clause 14 of Order No.7287, dated							
			207, 00120	 Designation / Authority : U.O. No. and date of 			
	19.09.2008	5).					
				Finance Deptt	. West Ber	ngal, it any:	

Part-II [Expenditure Statement of IPD treatment]

5. Det	5. Details of Treatment in Reimbursement Mode(If No is selected in SI. No 3)								
Period o	Period of treatment Admission Date Discharge date								
6. Тур	e of Discharge								
SI. No.	SI. No. Type of Discharge (Tick mark in appropriate box) SI. No. Type of Discharge						(Tick mark in appropriate box)		
6.1	Normal				6.3	Referral			
6.2	Risk Bond		□ 6.4		Death				
7.Amou	nt Claimed for								
Sl. No.	Sl. No. Type of Treatment					(Tick mark in appropriate box)			
6.1	1 Only Procedural/ Package Treatment								

6.2	Only Non- Procedural/ Non-Packag					
6.3	Both Procedural/ Package and Non- Procedural/ Non-Package					
	Treatment					
7.1 De						
Ре	riod of Procedural/ Package Treatn	nent	From			То
Sl.No.	Name of Procedures/ Pa	ackages		Proce	edure	Amount Claimed(Rs.)
				Со	de	
7.1.1						
7.1.2						
7.1.3						
7.1.4						
7.1.5						
					Total	
7.2 De	etails of Implants Used	1		[
Sl. No.	Name of Implants	Coded o		Impla		Amount Claimed (Rs.)
		cod	led	Code		
				code	ed	
7.2.1						
7.2.2						
7.2.3						
7.2.4						
7.2.5				Tatal	(Da)	
72 0-	tails of New Dressdarrol / New Deck			Total	(RS.)	
	tails of Non-Procedural/ Non-Pack of Non-Procedural/ Non-Package Tr	-	ient.	From		То
Sl. No.		Componen	+	From		To Amount Claimed
	Name of	Componen	it.			(Rs.)
7.3.1	Room/ Bed Rent					
	ICCU/ITU/ICU/NICU/PICU	From	1	То		
	HDU/SDU	From	1	То		
	Burn Unit	From	1	То		
	CRIB	From		То		
				_		
	General/Semi-Private/Private	From	n	То		
7.3.2	Consultation Fees.					
7.3.3	Pathological and Radiological Inve					
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)					-
	(amount mentioned in 7.1+7.2+7.3) No. of vouchers					

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

co a	o you want to claim Indoor related OPD tr ost i.e cost of OPD treatment 30 days dmission and 30 days after discharge? (Tick opropriate box)	prior to	Yes 🗆			No□
9. De	etails of Indoor related OPD Consultation					
	Dates		N	os. of	Consultation	
10. C	Details of Indoor related OPD treatment Ex	penditur	e			
SI.	Name of Com	nponents				Amount
No.						Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Inve	stigation	S			
10.3	Cost of Medicines					
	Period of medicine consumption	From		То		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
Total claim of indoor related OPD(Rs.)						
				Nos.	of vouchers	

Part-IV [Medical Advance]

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

Part-V [Refund of Medical Advance]

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

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

Part-VI [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Enrollment Certificate of beneficiary	Yes 🗆	No 🗆
2	Bill Summary of Indoor Treatment and OPD treatment	Yes 🗆	No 🗆
3	Money Receipts of both Indoor and OPD treatment in sequence manner (In chronological order)	Yes 🗆	No 🗆
4	Copy of related OPD Prescriptions (if claimed)	Yes 🗆	No 🗆
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	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	Yes 🗆	No□
8	Copy of Detailed Bill of Indoor Treatment	Yes 🗆	No 🗆
9	Original copy of Voucher/ Tax Invoice/Challan of Implants	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 Employee, Pensioner and Family Pensioner; 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 Employee/Pensioner/Claimant	:
Name in Block Letters	:
Designation/Last Designation	:

Form -C1

Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

Part-I[General Information]

1. D	1. Details of Employee/Pensioner.							
Full Name	9			HF	RMS ID / PPO I	No.		
Enrollmer	nt ID No.			Cla	aim Applicatio	n ID.		
Bed Entit	lement			Da	ate of Enrollme	ent		
2. D	etails of Patien	t, Treating Hospital and C	Condonatio	on R	equirement, i	f any.		
2.1	Name of Patier	nt						
-								
	Beneficiary ID							
	Relationship w	ith Employee/Pensioner						
2.2	Name of Empa	nelled/Enlisted hospital w	vhere					
	treatment was	availed.						
-	Code of Hospit	al						
	Class of Entitle	ment of Hospital						
-	Address of Hos	nital						
	Address of flos	pitai						
2.3	Requirement o	of approval of delay Condo	onation, if		Yes	No	Not known 🗆	
	any(Tick mark i	in appropriate box)						
3. D	etail of Claima	nt (Applicable in case of d	eath of em	ploy	vee or pension	er or family pe	ensioner)	
SI. No.		Name of claimant				Relati	on	
3.1								
				L				
	ermission Deta		1					
SI. No.					Is of permission	on approval		
4.1		nt availed in enlisted	Memo No	э.		:		
	•	side West Bengal (see	Date			:		
	-	order no.7287, dated	-	-	Authority	:		
	19.09.2008).		U.O. No.					
			Finance D	Dept	t. West Benga	l. if anv:		

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

5. I	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 7(1) and 7(2)]			As per clause OPD List	e 7(2) of					
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										
SI No.	Name of Components					int (Rs.)				

Reimbursement Application Form

6.1	6.1 Consultation Fees				
6.2					
6.3	Cost of Medicines				
	Period of medicine consumption	From	То		
6.4	Cost of Special Device				
6.5	Miscellaneous (specify)				
			Tot	tal	
			No. of vouche	ers	

Part-III [Medical Advance]

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

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

Part-V [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Annexure-I duly signed with proper stamp by Treating Specialist of an	Yes 🗆	No 🗆
	Empanelled/Enlisted Hospital		
2	Money Receipts in sequentially	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/ Challan of Implants	Yes 🗆	No 🗆
6	Copy of all investigation/ test reports in sequentially.	Yes 🗆	No 🗆
7	In case of death of Employee, Pensioner and Family Pensioner;		
	a. An affidavit on stamp paper by claimant	Yes 🗆	No□
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No 🗆
	c. Copy of death certificate	Yes 🗆	No 🗆
8	Filled ECS mandate form in case of those, whose bank details is not	Yes 🗆	No 🗆
	available in IFMS (in case of first claim only)		

		Reimbursement Appli	cation Form
9	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claiman	t:
Name in Block Letters	:
Designation/Last Designation	:

Form –C2

Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled Hospital

Under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

Part-I[General Information]

1.	Details of Emplo	yee/Pensioner.				
Full Na	ll Name HR			S ID / PPO No		
Enrolln	nent ID		Claim	n Application I	D	
Bed En	titlement		Date	of Enrollmen	t	
2.	Details of Patien	nt, Treating Hospital and Condo	natior	n Requiremen	t, if any	
2.1	Name of Patient					
	Beneficiary ID					
	Relationship wit	h Employee/Pensioner				
2.2	Name of Non-En	npanelled/hospital where treatr	nent			
	was availed.					
	Bed Capacity of	Hospital				
	CE Licence No.					
	CE Licence valid	up to				
	Address of Hosp	ital				
2.3	Requirement of	approval of delay Condonation,	if	Yes 🗆	No 🗆	Not known□
	any (Tick mark in appropriate box)					
3.	3. Details of Claimant (Applicable in case of death of employee or pensioner or family pensioner)					
SI. No.		Name of claimant			Rela	tion
3.1						

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

4. P	4. Period of treatment					
	Admission Date			Discharge date		
5. T	ype 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. A	mount Claimed for					
SI. No.		Type of Treatme	ent		Tick markin appropriate box	
6.1	Only Procedural/ Packa	ige Treatment				
6.2	Only Non- Procedural/	Package Treatment				
6.3	Both Procedural/ Packa	age and Non- Procedu	iral/ Packa	ge Treatment		
6.1 C	Details of Procedural/ Pa	ckage Treatment				
Р	eriod of Procedural/ Pa	ckage Treatment	From		То	
SI. No	. No Name of Procedures/ Packages			Amount Claimed (Rs.)		
6.1.1					. ,	
6.1.2						

6.1.3							
6.1.4							
6.1.5							
	1				Total		
6.2	Details of Implants Used					1	
Sl. No.		e of Impla	ants			Amou	unt Claimed
							(Rs.)
6.2.1							
6.2.2							
6.2.3							
6.2.4							
					Total		
6.3 C	Details of Non-Procedural/ Packag					1	1
	Period of Non-Procedural/ Packa	-		From		То	
Sl. No.	Name	of Compo	nents			Amou	unt Claimed (Rs.)
6.3.1	Room/ Bed Rent						
	ICCU/ITU/ICU/NICU/PICU	From		То			
	HDU/SDU	From		То			
	Burn Unit	From		То			
	CRIB	From		То			
	General/Semi-Private/Private	From		То			
6.3.2	Consultation Fees		•	•			
6.3.3	Pathological and Radiological Inv	vestigatior	าร				
6.3.4	Medicines						
6.3.5	Consumables						
6.3.6	Special Nursing/Aya Charges						
6.3.7	Miscellaneous. (If Any Specify)						
					Total		
				No	o. of Vouchers		
		Tota	al Treatme	ent Cost	[6.1+ 6.2+6.3]		
L							

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

Part-III [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules

Online Reimbursement Application Form

:

:

1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

[List o			
SI.	Name/Particulars of enclosures to be attached	Enclosed or not	
No.		1	
1	Annexure-II duly signed with proper stamp by the Medical		
	Superintendent of a Non-Empanelled Hospital	Yes 🗆	No 🗆
2	Bill Summary	Yes 🗆	No 🗆
3	Money Receipts in sequentially	Yes 🗆	No 🗆
4	Copy of Discharge Summary (Case summary in case of death) and OT		
	note and copy of death certificate	Yes 🗆	No 🗆
5	Detailed Bill	Yes 🗆	No 🗆
6	Original copy of Voucher/ Tax Invoice/ Challan of Implants	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 Employee, Pensioner and Family Pensioner;		
	a. An affidavit on stamp paper by claimant	Yes 🗆	No□
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No□
	c. Copy of death certificate	Yes 🗆	No□
10	Filled ECS mandate form in case of those, whose bank details is not	Yes 🗆	No 🗆
	available in IFMS (in case of first claim only)		
11	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant:

Name in Block Letters

Designation/Last Designation

Form –C3

Reimbursement for cost of Cashless In-Patient Department (IPD) treatment in Empanelled Hospital

Under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

Part-I[General Information]

1. D	etails of Employee/Pensioner				
Full Na	ame		HRMS ID ,	/ PPO No.	
Enrollr	ment ID No.		Claim App	plication ID.	
Bed Er	ntitlement		Date of Er	nrollment	
2. D	etails of Patient, Treating Hospital and Cond	onatio	n Requirement, if any		
2.1	Name of Patient				
	Beneficiary ID				
	Relationship with Employee/Pensioner				
2.2	Name of 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	Yes	□ No □	l 🛛 Not known 🗆	
	Condonation, if any (Mark in appropriate				
	box)				
3. D	etails of Claimant (applicable in case of death	-	ployee or pensioner or	family pensioner)	
Sl.No.	Name of claima	nt		Relation	
3.1					
	ermission Details (If any)				
SI. No.	Permission sought		Details of permission approval		
4.1	4.1 For treatment availed in empane		Permission ID	:	
	private hospital within West Beng	al[see	Permission approved	for:	
	clause 14 of Order No. 796 and 797,				
	31.01.2011, 11253-F(MED), dated; 16.12.201	1 and			
	7578-F(MED) dated;04.09.2012]				

Part-II [Expenditure Statement of IPD treatment]

5. Detai	5. Details of Treatment in Cashless Mode								
SI. No.	Particulars		Details						
5.1	Transaction ID of Cashles	ss Treatment							
5.2	Treatment Period	Admission Date		Discharge Date					
5.3	Total Treatment Cost (Rs	.)							
5.4	Cashless Admissible Rein	nbursement Certificate (CARC)No.						
7.5	Amount paid to hospital	(Rs.)							
5.6	Amount admissible for re	ARC (Rs.)							
	Total Claim	ment(Rs.)							
	Tota	y Receipts							

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

6.	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	Yes 🗆	No□
	appropriate box)		
7.	Details of Indoor related OPD Consultation		

	Dates		N	os. of	Consultation	
8. De	tails of Indoor related OPD treatment E	xpenditure				
SI.	Name of C	omponents				Amount
No.						Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological In	vestigation	S			
8.3	Cost of Medicines					
	Period of medicine consumption	From		То		
8.4	Cost of Special Devices					
8.5	Miscellaneous (specify)					
		Total clair	n of indoor	relate	ed OPD (Rs.)	
				Nos.	of Vouchers	

Part-IV [Medical Advance]

9. Details of Medical Advance, if any								
DDO	Designation of DDO	Treasury	Treasury	Amount				
Code		Voucher No.	Voucher Date	(Rs.)				
	DDO	DDO Designation of DDO	DDO Designation of DDO Treasury	DDO Designation of DDO Treasury Treasury				

Part-V [Refund of Medical Advance]

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

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

Part-VI [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Sl. No.	Name/Particulars of Enclosures to be attached	Enclose	d 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	Copy of related OPD Prescriptions sequentially (if claimed)	Yes 🗆	No 🗆
4	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes 🗆	No 🗆
5	Copy of Form-H	Yes 🗆	No 🗆
6	Copy of Form-D4	Yes 🗆	No 🗆
7	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes 🗆	No 🗆
8	 In case of death of Employee, Pensioner and Family Pensioner; 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	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes 🗆	No 🗆
10	Any other instruments (Specify)	Yes 🗆	No 🗆

Date:

Signature of the Employee/Pensioner/Claimant	:
Name in Block Letters	:
Designation/Last Designation	:

Form –C4

Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital

Under West Bengal Health Scheme

(Generated by employee/pensioner from Health Portal)

Part-I[General Information]

1. D	Details of Employee/Pensioner	
Full Na	ame	HRMS ID / PPO No.
Enroll	ment ID No.	Claim Application ID.
Bed Er	ntitlement	Date of Enrollment
2. D	Details of Patient, Treating Hospital and Cond	onation Requirement, if any
2.1	Name of Patient	
	Beneficiary ID	
	Relationship with Employee/Pensioner	
2.2	Name of 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	Yes No Not known
	Condonation, if any (Tick mark in	
	appropriate box)	
		eath of employee or pensioner or family pensioner)
SI. No	o. Name of claim	ant Relation
3.1		
4. P	Permission Details (If any)	
SI. No	Permission sought	Details of permission approval
4.1	For treatment availed in empanel	
	i di di cadificite avallea ili cimpatici	ed Permission ID :
	private hospital within West Bengal	
	•	Permission approved for:
	private hospital within West Bengal clause 14 of Order No. 796 and 797, dat 31.01.2011, 11253-F(MED), dated; 16.12.20	Permission approved for:
	private hospital within West Bengal clause 14 of Order No. 796 and 797, dat 31.01.2011, 11253-F(MED), dated; 16.12.20 and 7578-F(MED) dated;04.09.2012]	Permission approved for: red
4.2	private hospital within West Bengal clause 14 of Order No. 796 and 797, date 31.01.2011, 11253-F(MED), dated; 16.12.20 and 7578-F(MED) dated;04.09.2012] For treatment availed in enlist	Permission approved for: red 11 ed Memo No. :
4.2	private hospital within West Bengal clause 14 of Order No. 796 and 797, data 31.01.2011, 11253-F(MED), dated; 16.12.20 and 7578-F(MED) dated;04.09.2012] For treatment availed in enlist hospital outside West Bengal (s	Permission approved for: ed Memo No. : ee Date :
4.2	private hospital within West Bengal (sclause 14 of Order No. 796 and 797, data 31.01.2011, 11253-F(MED), dated; 16.12.20 and 7578-F(MED) dated;04.09.2012] For treatment availed in enlist hospital outside West Bengal (sclause 14 of Order No.7287, data sclause 14 of Order No.7287	Permission approved for: red 11 ed Memo No. : red Date : ed Designation / Authority :
4.2	private hospital within West Bengal clause 14 of Order No. 796 and 797, data 31.01.2011, 11253-F(MED), dated; 16.12.20 and 7578-F(MED) dated;04.09.2012] For treatment availed in enlist hospital outside West Bengal (s	Permission approved for: ed Memo No. : ee Date :

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

5. Det	5. Details of Treatment in Reimbursement Mode (If No is selected in Sl. No 3)								
Period o	Period of treatment Admission Date Discharge date								
6. Тур	6. Type of Discharge								
SI. No. Type of Discharge (Tick mark in appropriate box) SI. No. Type of Discharge (Tick mark in appropriate box)									
6.1	Normal				Referral				
6.2	Risk Bond			6.4	Death				
7. Am	7. Amount Claimed for								
SI. No.	o. Type of Treatment (Tick mark in								
						appropriate box)			
7.1	Only Procedural/ Pa	ckage Treatmer	nt						

	Only Non- Procedural/ Non-Package Treatment					
7.3	Both Procedural/ Package and Non- Procedural/ Non-Package					
	Treatment					
	tails of Procedural/ Package Treatr		I			1
	riod of Procedural/ Package Treatn		From			То
Sl. No.	Name of Procedures/ Packages					Amount Claimed(Rs.)
				Со	de	
7.1.1						
7.1.2						
7.1.3						
7.1.4						
7.1.5					Total	
7.2 De	etails of Implants Used				TOLAI	
Sl. No.	Name of Implants	Coded o	or Non-	Impla	nts	Amount Claimed (Rs.)
51. 10.	Name of implants	cod		Code		Amount claimed (NS.)
1			cu	code		
7.2.1						
7.2.2						
7.2.3						
7.2.4						
7.2.5						
				Total	(Rs.)	
7.3 De	tails of Non-Procedural/ Non-Pack	age Treatm	nent.			
			-			
	riod of Non-Procedural/ Non-Packa	-		From		То
Per Sl. No.		ge Treatm Componen		From		Amount Claimed (Rs.)
		-		From		Amount Claimed
Sl. No.	Name of Room/ Bed Rent	-	ts	From To		Amount Claimed
Sl. No.	Name of Room/ Bed Rent	Componen	ts 1			Amount Claimed
Sl. No.	Name of Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU	Componen From From	ts 1	То То		Amount Claimed
Sl. No.	Name of Room/ Bed Rent	Componen From	ts 1	То		Amount Claimed
Sl. No.	Name of Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU	Componen From From		То То		Amount Claimed
Sl. No.	Name of Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit	Componen From From From		To To To		Amount Claimed
Sl. No.	Name of Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit	Componen From From From		To To To		Amount Claimed
Sl. No.	Name of Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB	Componen From From From From		То То То То		Amount Claimed
Sl. No. 7.3.1	Name of O Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Inve	Componen From From From From From		То То То То		Amount Claimed
Sl. No. 7.3.1 7.3.2 7.3.2 7.3.3 7.3.4	Name of O Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Inve Medicines.	Componen From From From From From		То То То То		Amount Claimed
Sl. No. 7.3.1 7.3.2 7.3.2 7.3.3 7.3.4 7.3.5	Name of O Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Inve Medicines. Consumables	Componen From From From From From		То То То То		Amount Claimed
Sl. No. 7.3.1 7.3.2 7.3.3 7.3.4 7.3.5 7.3.6	Name of O Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Inve Medicines. Consumables Special Nursing/Aya Charges	Componen From From From From From		То То То То		Amount Claimed
Sl. No. 7.3.1 7.3.2 7.3.2 7.3.3 7.3.4 7.3.5	Name of O Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Inve Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify)	Componen From From From From stigations.		To To To To To To		Amount Claimed (Rs.)
Sl. No. 7.3.1 7.3.2 7.3.3 7.3.4 7.3.5 7.3.6	Name of O Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Inve Medicines. Consumables Special Nursing/Aya Charges	Componen From From From From stigations.	ts	To To To To To To	-	Amount Claimed (Rs.)

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

Online Reimbursement Claim Form

co: ad	you want to claim Indoor related OPD tr st i.e cost of OPD treatment 30 days mission and 30 days after discharge? (Tick propriate box)	prior to	Yes 🗆			No□
9. Det	ails of Indoor related OPD Consultation					
	Dates		Ν	os. of	Consultation	
10. D	etails of Indoor related OPD treatment Ex	penditur	e			
SI. No.	Name of Cor	nponents	5			Amount
						Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Inv	estigatior	าร			
10.3	Cost of Medicines					
	Period of medicine consumption	From		То		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	Т	otal clair	n of indoor	relate	ed OPD (Rs.)	
				Nos.	of vouchers	

Part-IV [Medical Advance]

11. Details of Medical Advance, if any								
DDO	Designation of DDO	Treasury	Treasury	Amount				
Code		Voucher No.	Voucher Date	(Rs.)				
	DDO	DDO Designation of DDO	DDO Designation of DDO Treasury	DDO Designation of DDO Treasury Treasury				

Part-V [Refund of Medical Advance]

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

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

Part-VI [Declaration of Employee/Pensioner]

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 are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

Online Reimbursement Claim Form

:

:

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	Copy of related OPD Prescriptions sequentially (if claimed)	Yes 🗆	No 🗆	
4	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	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	Yes 🗆	No口	
7	Copy of Detailed Bill of Indoor Treatment	Yes 🗆	No 🗆	
8	Original copy of Voucher/ Tax Invoice/Challan of Implants	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 Employee, Pensioner and Family Pensioner; 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 Employee/Pensioner/Claimant: Name in Block Letters Designation/Last Designation

Annexure-I

Certification of Treating Specialist of <u>Empanelled Hospital</u> for claiming reimbursement of <u>"Out Patient</u>" <u>Department"</u> treatment under WBHS

1.	Certified that the patient, Sri/Smt	is a beneficiary of West
	Bengal Health Scheme having the Beneficiary ID is	

2. S/he has been suffering from _______ (specify name of disease) as listed in SI. No. _______ of the OPD list as per 7(1) clause or follow-up medical attendance and treatment of _______ as per 7(2) clause of order number 7287-F, dated 19/09/2008 issued by Medical Cell, Finance Department, Government of West Bengal.

Date:

Signature of the Treating Specialist
Registration No:
Registering Authority:
Present Degree:
Hospital

Official Seal of Treating Hospital

List of OPD (Out-Patient Department) Diseases

As per clause 7(1) of 7287			As per clause 7(1) of 7287–F, dated; 19-09-2008		
SI. No	Name of Disease	SI. No	Name of Disease	SI. No	Name of 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.				

Annexure-II

Certification of Medical Superintendent/ Administrative Officer and Treating Specialist of treating in <u>Non-Empanelled Hospital</u> for claiming reimbursement of only <u>"Indoor"</u> treatment under WBHS

1.	Certified that the patient, Sri/Smt	is	а
	beneficiary of West Bengal Health Scheme having the Beneficiary		ID
	is availed indoor treatment 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 und	er t	:he
	West Bengal Clinical Establishment Act and Rules bearing no and this Lice	nse	e is

valid up to _____.

Date:

Signature of Medical Superintendent Hospital Official Seal of the Hospital