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

Manual/ Offline Reimbursement Application Form

Form -C1

Reimbursement for cost of Out-Door Patient (OPD) 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. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
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 Patient, Treating Hospital and Condonation Requirement, if any.		
2.1	Name of Patient	
2.2	Name of 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 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 enlisted hospital outside West Bengal *(see clause 14 of order no.7287, dated 19.09.2008*).	Memo No. : Date: Designation / Authority : U.O. No. and dateof 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 7(1) and 7(2)]*	As per clause 7(1) of OPD List	☐	As per clause 7(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.	Name of Components	Amount

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

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of 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 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 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.

[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	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 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 :

Manual/ Offline Reimbursement Application Form

Form –C2

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. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID *(To be filled at the time of online entry from end the Head of Office)*	

2. Detail of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Non-Empanelled/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. Detail of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of 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]					

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.

[List of Enclosures]

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

No.			
1	**Annexure-II** duly signed with proper stamp by the Medical Superintendent of a Non-Empanelled Hospital	Yes ☐	No ☐
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 treatment summary or bed head ticket in case of non-procedural/package treatment	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 :

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. Details of Employee/Pensioner			
Full Name *(in Block letters)*		HRMS ID / PPO No.	
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 Patient, Treating Hospital and Condonation Requirement, if any**				
2.1	Name of Patient			
2.2	Name of Empanelled/Enlisted hospital where treatment was availed			
2.3	Requirement of approval of delay Condonation, if any (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:

Part-II [Expenditure Statement of IPD treatment]

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 hospital at the time of discharge)*				
5.2	Treatment Period	Admission Date		Discharge Date	
5.3	Total Treatment Cost (Rs.)				
5.4	Cashless Admissible Reimbursement Certificate (CARC)No.				
5.5	Amount paid to hospital (Rs.)				
5.6	Amount admissible for reimbursement against CARC(Rs.) *(See Row no. 16 of CARC generated through system)*				
	Total Claim of Indoor Cashless Treatment (Rs.) *(amount mentioned in 5.6)*				
	Total nos. of Vouchers/Money 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 appropriate box)	**Yes** ☐	**No**☐

7. Details of Indoor related OPD Consultation

Dates	Nos. of Consultation

8. Details of Indoor related OPD treatment Expenditure

Sl. No.	Name of Components					Amount Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Investigations					
8.3	Cost of Medicines					
	Period of medicine consumption	From		To		
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 where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

10. Details of Refund of Medical Advance, if any

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

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed 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 ☐
8	Copy of all investigations/ tests report of Indoor related OPD treatment sequentially	Yes ☐	No ☐
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. Details of Employee/Pensioner			
Full Name *(in Block letters)*		HRMS ID / PPO No.	
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 Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of 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 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 14 of Order No.7287, dated 19.09.2008*).	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(If No is selected in Sl. No 3)				
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)
6.1	Only Procedural/ Package Treatment	☐

6.2	Only Non- Procedural/ Non-Package Treatment	☐
6.3	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 of Indoor related OPD treatment Expenditure

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]

12. Details of Medical Advance, if any

Name of 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]

13. Details of Refund of Medical Advance, if any

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

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed 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. Details of Employee/Pensioner.			
Full Name		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrollment	

2. Details of Patient, Treating Hospital and Condonation 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 Condonation, if any(Tick mark in appropriate box)	Yes☐ No☐ Not known ☐

3. Detail 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 enlisted hospital outside West Bengal *(see clause 14 of order no.7287, dated 19.09.2008*).	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 7(1) and 7(2)]*	As per clause 7(1) of OPD List	☐	As per clause 7(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	Consultation Fees					
6.2	Cost of Pathological and Radiological Investigations					
6.3	Cost of Medicines					
	Period of medicine consumption	From		To		
6.4	Cost of Special Device					
6.5	Miscellaneous (specify)					
					Total	
					No. of vouchers	

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of 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 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 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.

[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	Yes ☐	No ☐
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 b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
8	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐

9	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant:
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 Employee/Pensioner.			
Full Name		HRMS ID / PPO No.	
Enrollment ID		Claim Application ID	
Bed Entitlement		Date of Enrollment	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
	Beneficiary ID	
	Relationship with Employee/Pensioner	
2.2	Name of 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 or pensioner or family pensioner)*		
Sl. No.	Name of 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 markin 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]					

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.

[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 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 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 –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. Details of Employee/Pensioner			
Full Name		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrollment	

2. **Details of Patient, Treating Hospital and Condonation 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 Condonation, if any (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:

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Cashless Mode					
Sl. No.	Particulars			Details	
5.1	Transaction ID of Cashless Treatment				
5.2	Treatment Period	Admission Date		Discharge Date	
5.3	Total Treatment Cost (Rs.)				
5.4	Cashless Admissible Reimbursement Certificate (CARC)No.				
7.5	Amount paid to hospital (Rs.)				
5.6	Amount admissible for reimbursement against CARC (Rs.)				
	Total Claim of Indoor Cashless Treatment(Rs.)				
	Total nos. of Vouchers/Money 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 appropriate box)	**Yes ☐**	**No☐**
7. Details of Indoor related OPD Consultation		

Dates	Nos. of Consultation

8. Details of Indoor related OPD treatment Expenditure						
Sl. No.	Name of Components					Amount Claimed (Rs.)
8.1	Consultation Fees					
8.2	Cost of Pathological and Radiological Investigations					
8.3	Cost of Medicines					
	Period of medicine consumption	From		To		
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 where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

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

[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	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. Details of Employee/Pensioner			
Full Name		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrollment	

2. Details of Patient, Treating Hospital and Condonation 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 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 14 of Order No.7287, dated 19.09.2008*).	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 (If No is selected in Sl. No 3)				
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 of Indoor related OPD treatment Expenditure

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

[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	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 ☐
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 **Empanelled Hospital** for claiming reimbursement of **"Out Patient Department"** 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 Sl. 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–F, dated; 19-09-2008				As per clause 7(2) of 7287–F, dated; 19-09-2008	
Sl. No	**Name of Disease**	**Sl. No**	**Name of Disease**	**Sl. 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 **Non-Empanelled Hospital** for claiming reimbursement of only **"Indoor"** treatment under WBHS

1. Certified that the patient, Sri/Smt._____ is a 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 under the West Bengal Clinical Establishment Act and Rules bearing no. _____ and this License is valid up to _____.

Date:

Signature of Medical Superintendent
..... Hospital
Official Seal of the Hospital