Government of West Bengal
Finance Department
Medical Cell, Writers 'Building

No. 48 -F (MED)WB

Dated:29.03.2022

ORDER

Sub: Introduction of online processing of Advance claim through WBHS Portal under West Bengal Health Scheme.

Online processing of medical reimbursement claim through WBHS Portal has been introduced vide Finance Department Notification No. 127-F(MED)WB dated 26.11.2021. But, processing of advance drawal against cost of ongoing OPD/IPD treatment is still being processed manually on the basis of the estimate from the recognised hospitals under the WBHS.

As such, online processing of such advance claim through WBHS Portal and making payments thereof through WBIFMS Portal in integrated mode was under active consideration for some time past.

Now, after careful consideration, the Governor is pleased to introduce the online processing of medical advance claim through WBHS Portal with the following guidelines, new set of Forms and Pro-forma Estimate from the Hospital for processing and settlement of the claim:-

1. Guidelines of process flow for online advance claim through WBHS Portal mentioned in Appendix-I.
2. Form-C5 of advance claim for Out-Patient Department (OPD) treatment in State Aided /Private Empanelled/ Outside State Enlisted Hospital.
3. Form-C6 of advance claim for In-Patient Department (IPD) treatment in State Aided /Private Empanelled/ Outside State Enlisted Hospital.
4. Pro-forma of Cost Estimate (Annexure-III) for Out Patient Department (OPD) treatment.
5. Pro-forma of Cost Estimate (Annexure-IV) for In Patient Department (IPD) treatment.

Online processing of advance claim through WBHS Portal is optional for all treatments till 30.06.2022 and it is mandatory thereafter.

This has the approval of Principal Secretary, Finance Department, Government of West Bengal.

Enclosures: As stated

ALOKE KUMAR MUKHERJEE, WBA & AS
Joint Secretary, Finance Department
Government of West Bengal

Appendix-I

(As per Order No.48-F(MED)WB dated.29.03.2022)

(Process flow for online advance claim through WBHS Portal)

1. Only enrolled employee (pensioner is not eligible) under WBHS may draw advance for meeting up the expenditure for ongoing/future treatment in recognized hospitals within State or enlisted hospitals outside State.
2. An employee will have to collect duly signed and stamped Estimate of Expenditure from treating the hospital for taking advance.
3. Treating hospital will issue Cost Estimate for a maximum period of 60(sixty) days for OPD and 15(fifteen) days for IPD treatment in a specified format to the employee.
4. Empanelled private hospital of the State shall issue **system generated Cost Estimate** from WBHS Portal using their credential. On the other hand State aided hospitals and enlisted hospital outside State will issue in **manual mode**.
5. On request empanelled hospital authority will issue system generated Cost Estimate using their credential in WBHS Portal. When hospital generates it in portal, a 12 (twelve) digit unique ID will be generated and enfaced in the top right of Cost Estimate. Hospital authority will hand over duly signed and stamped Cost Estimate to the employee or his/her relatives. In case of any wrong information mentioned in Cost Estimate, hospital can reject previous one for issuing a fresh one.
6. When employee collect portal generated Cost Estimate from private empanelled hospital of State, the information of advance claim will be filled automatically and to be shown as a claim in **"Claim Pending for Submission"** under **'My Claim'** menu in the login of employee in WBHS Portal. On the other hand, when employee gets Cost Estimate from State aided hospitals or enlisted hospital outside State, s/he has to incorporate the information of advance in WBHS Portal using his/her personal login in the Advance menu under '**My Claim**'. Employee will submit the claim electronically.
7. Claim will reach automatically to the Operator (Reimbursement) with whom the employee is mapped for reimbursement claim processing.
8. After online submission, employee shall have to take a print out of system generated form of claim submitted. Then s/he signs in the appropriate space provided in the form. S/he will have to attach all necessary enclosures chronologically mentioned in last part of the claim form. Finally signed copy of such claim form must be submitted physically to the office of the Head of Office at the earliest.
9. After receiving the advance claim at office of the Head of Office, the sanction order will be generated as per guidelines as laid down under Clause No. 13 to 23 of Appendix-I of Finance Department Notification No. 127-F(MED)WB dated 26.11.2021.
10. Appendix-II of Notification No. 127-F(MED)WB dated 26.11.2021 shall be applicable for PAO/Treasury Bill preparation in TR Form-68C and subsequent disbursement.

SRI ALOKE KUMAR MUKHERJEE, WBA & AS
Joint Secretary, Finance Department
Government of West Bengal

Form –C5

Out-Patient Department (OPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(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 where Employee attached)

To
The ..... (Designation of HoO)
..... (Name of the Office)
..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards **Advance** of cost of Out-Patient Department (OPD) treatment at state aided/ private empanelled / enlisted hospital under West Bengal Health Scheme as per details stated below:

Part-I[General Information]

1. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID	
Enrolment 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.		
2.1	Name of the Patient	
2.2	Name of hospital where treatment is going on or to be availed	

Part-II [Details of Cost Component of Estimate]

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

4. Cost Component of OPD treatmentas per estimate submitted by state aided/ private empanelled/outside state enlisted hospital					
Sl. No.	Name of Component	Nos.	Period		Amount (Rs.)
			From	To	
4.1	Consultation fees				
4.2	Cost of pathological and radiological Investigations				
4.3	Cost of medicines				

4.4	Cost of implant / special device				
4.5	Miscellaneous (specify)				
				Total	

Part-III [Advance Amount Selection Clause]

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

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

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

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

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :

Online Advance Application Form

Form –C5

Out-Patient Department (OPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(Generated by Employee from WBHS Portal)

To
The ..... (Designation of HoO)
..... (Name of the Office)
..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards advance for cost of Out-Patient Department (OPD) treatment at state aided/ private empanelled / enlisted hospital under West Bengal Health Scheme as per details stated below:

Part-I[General Information]

1. Details of Employee/Pensioner			
Full Name		HRMS ID.	
Enrolment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	

2. Details of Patient, Treating Hospital		
2.1	Name of the Patient	
	Beneficiary ID	
	Relationship with Employee	
2.2	Name of hospital where treatment is going on or to be availed	
	Code of Hospital	
	Class of Entitlement of Hospital	
	Address of Hospital	

Part-II [Details of Cost Component of Estimate]

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

4. Cost Component ofOPDtreatmentas per Estimate submitted by the state aided/ private empanelled/outside state enlisted hospital					
Sl. No.	Name of Component	Nos.	Period		Amount (Rs.)
			From	To	
4.1	Consultation fees				
4.2	Cost of pathological and radiological				

	Investigations				
4.3	Cost of medicines				
4.4	Cost of implant / special device				
4.5	Miscellaneous (specify)				
				Total	

Part-III [Advance Amount Selection Clause]

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

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

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Original Cost Estimate issued by treating hospital	Yes ☐	No ☐
2	Prognosis Report of patient issued by the Treating Consultant	Yes ☐	No ☐
3	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :

Form –C6

In-Patient Department (IPD)Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(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 where Employee attached)

To
The ..... (Designation of HoO)
..... (Name of the Office)
..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards **Advance** of cost of In-Patient Department (IPD) treatment at state aided/ private empanelled / outside state enlisted hospital under West Bengal Health Scheme as per details stated below:

Part-I[General Information]

1. Details of Employee			
Full Name *(in Block letters)*		HRMS ID	
Enrolment 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		
2.1	Name of the Patient	
2.2	Name of hospital where treatment is going on or to be availed	

Part-II [Details of Cost Component of Estimate]

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

3.3 Estimate cost of Implants Used				
Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount (Rs.)
3.3.1				
3.3.2				
3.3.3				
3.3.4				
3.3.5				

	Total (Rs.)	
3.4 Estimate cost of Non-Package Treatment.		
Sl. No.	Name of Component	Amount (Rs.)
3.4.1	Room/ Bed rent	
3.4.2	Consultation fees.	
3.4.3	Cost of pathological and radiological investigations.	
3.4.4	Cost of medicines.	
3.4.5	Cost of consumables	
3.4.6	Charges of special nursing/aya	
3.4.7	Miscellaneous. (specify)	
	Amount of Total Estimate submitted by Hospital(Rs.) (amount mentioned in 3.2+ 3.3+3.4)	

3.5 Mode of Treatment		
Availing Cashless Facility? (Tick mark in appropriate box)	Yes ☐	No ☐

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance If answer of 3.5 is yes {80 % of(3.2+ 3.3+3.4) minus Rs. 1,00,000.00} or If answer of 3.5 is No 80 % of (3.2+ 3.3+3.4)	
2	Amount of Advance Applied for	

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

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Enrolment certificate of the patient	Yes ☐	No ☐
2	Original Cost Estimate issued by treating hospital	Yes ☐	No ☐

3	Prognosis Report of patient issued by the Treating Consultant	Yes ☐	No ☐
4	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only)	Yes ☐	No ☐
5	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :

Form –C6

In-Patient Department (IPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(Generated by Employee from WBHS Portal)

To
The ..... (Designation of HoO)
..... (Name of the Office)
..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards **Advance** of cost of In-Patient Department (IPD) treatment at state aided/ private empanelled / outside state enlisted hospital under West Bengal Health Scheme as per details stated below:

Part-I[General Information]

1. Details of Employee			
Full Name		HRMS ID.	
Enrolment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	

2. Details of Patient, Treating Hospital		
2.1	Name of the Patient	
	Beneficiary ID	
	Relationship with Employee	
2.2	Name of hospital where treatment is going on or to be availed	
	Code of Hospital	
	Class of Entitlement of Hospital	
	Address of Hospital	

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital	
3.1 No. of days for which hospital produced Estimated Expenditure	**( ) days**

3.2 Estimate cost of Package Treatment

Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount (Rs.)
3.2.1			
3.2.2			
3.2.3			
3.2.4			
3.2.5			
		Total	

3.3 Estimate cost of Implants Used

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

3.3.3				
3.3.4				
3.3.5				
			Total (Rs.)	

3.4 Estimate cost of Non-Package Treatment.		
Sl. No.	Name of Component	Amount (Rs.)
3.4.1	Room/ Bed rent	
3.4.2	Consultation fees.	
3.4.3	Cost of pathological and radiological investigations.	
3.4.4	Cost of medicines.	
3.4.5	Cost of consumables	
3.4.6	Charges of special nursing/aya	
3.4.7	Miscellaneous. (specify)	
	Amount of Total Estimate submitted by Hospital(Rs.) (amount mentioned in 3.2+ 3.3+.4)	

3.5 Mode of Treatment		
Availing Cashless Facility? (Tick mark in appropriate box)	Yes ☐	No☐

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance If answer of 3.5 is yes {80 % of (3.2+ 3.3+3.4) minus Rs. 1,00,000.00} or If answer of 3.5 is No 80 % of (3.2+ 3.3+3.4)	
2	Amount of Advance Applied for	

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

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Original Cost Estimate issued by treating hospital	Yes ☐	No ☐
2	Prognosis Report of patient issued by the Treating Consultant	Yes ☐	No ☐
3	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :

Annexure-III

(As per Order No.48-F(MED)WB, dated 29/03/2022)

Cost Estimate

(Required for applying advance of OPD treatment)

A. Patient Information		
Sl. No.	Particulars	Details
1	Name of the patient	
2	Beneficiary ID of the patient	
3	Enrolment ID of the employee	
4	Duration of treatment (maximum admissible duration 60 days)	From To
5	Name of disease*[Bita-Thallsaemia/ Hepatitis-C/ Carcinoma including Multiple Myelomais]*	
6	Expected nos. of consultation	

B. Estimate		
Sl. No.	Name of cost component	Amounts (Rs)
1	Consultation fees	
2	Cost of pathological and radiological Investigations	
3	Cost of medicines	
4	Cost of implant / special device	
5	Miscellaneous (if any)	
	Total	
Rupees in words:		

Other declarations if any (given by hospital)

Signature of Treating Consultant with date and official stamp

Signature of MS/CEO/FD/Admn Officer with date and official stamp

Note: *Cost Estimate shall be issued in official letter head of the hospital.*

Annexure-IV

(As per Order No.48-F(MED)WB, dated 29.03.2022)

Cost Estimate

(Required for applying advance of IPD treatment)

A. Patient Information		
Sl. No.	Particulars	Details
1	Name of the patient	
2	Beneficiary ID of the patient	
3	Enrolment ID of the employee	
4	Date or expected date of admission	
5	Period of package treatment	From To
6	Period of non-package treatment	From To
7	No. of days for which hospital furnished the estimate (maximum admissible duration 15 days)	
8	Type of IPD treatment [Package (Surgical)/*Non-Package / Both Package and Non-package]*	
9	Covering cashless facility	Yes/No

B. Estimatefor Package(Surgical) Treatment		
Sl. No.	Name of cost component	Amounts (Rs)
1	Name of Procedure (if more than one procedure is planned, it has to be mentionedchronologically)	
2	Cost of implant used /to be used	
	Total	

C. Estimatefor Non-PackageTreatment		
Sl. No.	Name of cost component	Amounts (Rs)
1	Bed/Room rent	
2	Consultation fees	
3	Cost of pathological and radiological Investigations	
4	Cost of medicines	
5	Cost of consumables	
6	Charges of special nursing/ayah	
7	Miscellaneous. (if any)	
	Total	

Total Cost (B+C) in figure:
Total Cost in words :

Other declarations if any (given by hospital)

Signature of Treating Consultant with date and official stamp

Signature of MS/CEO/FD/Admn Officer with date and official stamp

Note: *Cost Estimate shall be issued in official letter head of the hospital.*