Form Sl. No……..
(For Office use)

FORM A

Application for enrolment

To
The Competent Authority
Maavoi West Bengal Health Scheme for the Journalists, 2016
Information & Cultural Affairs Department
Government of West Bengal

Sir,

I, Shri/Smt. …… (designation)……..
attached to …… under ……..
do hereby opt. for coming under the "Maavoi - West Bengal Health Scheme for the Journalists, 2016",
with effect from …… .

The particulars of the members of my family as defined in clause (iv) of the Scheme are as follows:

Name of the Journalist :

Designation :

Residential address :

Date of birth :

Accreditation Card Number
with validity date. :
(attach photocopy of Press Card)

Details of Family:-

Sl. No.	Name	Age	Relationship	Monthly Income, If any	Affix stamp Size Photo	Signature of the beneficiary
1.						
2.						

3.						
4.						
5						
6						

I hereby declare that the particulars furnished by me are true to the best of my knowledge & belief and I shall abide by the provisions of the "Maavoi - West Bengal Health Scheme for the Journalists, 2016", as may be in force from time to time.

Counter Signature of the Editor/
Channel Head/ News Editor with
Seal & Date

Signature of the Applicant
with Date

(NB:- In support of relationship, please attach self attested photocopy of voter I D Card /Aadhar Card / Ration Card / Passport/ Driving Licence/Pan Card/Birth Certificate. Monthly income certificate depending parents to be submitted, as prescribed in the guidelines.)

FORM B

Certificate for enrolment

No. -ICA Date:

Certified that Shri/Smt. ……

(designation)……..attached to ……

under …….. has been enrolled under the Maavoi West Bengal Health Scheme for the Journalists, 2016, with effect from …… in terms of I & C A Department's Notification No.509-ICA(N) dated 25.02.2016.

The particulars of the members of my family as defined in clause (iv) of the Scheme are as follows:

Name of the Journalist :

Designation :

Residential address :

Date of birth :

Accreditation Card Number with validity date :

Details of Family:-

Sl.No.	Name	Age	Relationship	Monthly income, If any	Stamp size Photograph
1.					
2.					
3.					

4.					
5.					
6.					

O.S.D. & E.O. Special Secretary

No. /1(6)-ICA Date:

Copy forwarded for information and necessary action to:-

1.Shri/Smt……(designation)……..

2.The Office of the Pr. A.G.(A&E), W.B. Treasury Buildings, Kolkata-1.

3.The Finance Department(Medical Cell) of this Government.

4.Director of Information of this Department.

5.Cell …….. of this Department.

O.S.D. & E.O. Special Secretary

FORM C

Application Form for settlement of claim for reimbursement under the Maavoi West Bengal Health Scheme for the Journalists, 2016

(To be filled in by the applicant)

1. Press Card No. of the Journalist :

2. Full name of the Journalist with designation (in Block letters) :

3. Full Address:
   (i) Office :

   (ii)Residence :

4. Enrolled under the Health Scheme w.e.f. :

5. Accommodation Category [put (√) mark)] : Semi-Private/ General Ward

6. Medical treatment done : Self or beneficiary

7. Name of the beneficiary & relationship with the Journalist :

8. Name of the Hospital with address and code no.
   (a) OPD treatment :

   (b) Indoor treatment/ Day Care :

9. Period of OPD treatment :

10. Period of indoor treatment :

11. Disease :

12. Total amount claimed-
    (a) OPD treatment :
    (b) Indoor treatment :
    Total :

13. Details of permission
    (a) For treatment in speciality hospital outside the State :
    (b) For human organ transplantation/ ICD/ CRT/ Dual Chamber Pacemaker/ more than two stents/ more than one drug eluting stents, digital hearing aid, etc.. :

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am a beneficiary of the Maavoi West Bengal Health Scheme for the Journalists, 2016, and the enrolment under the Scheme was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Signature of the Journalist

Date:

Counter signature of the Editor/Channel Head/News Editor of the Media House with Office Seal & Date

Maavoi West Bengal Health Scheme for the Journalists, 2016

FORM "D_1"

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

1. Name of the Journalist with Press Card No. :

2. Name of Office of the Journalist with address :

3. Name of the patient, relationship with Journalist & Press Card No. :

4. Details of expenditure:

(I) Name of the diagnosed disease :
(* vide list enclosed)

(II) Name & Code No. of the empanelled/ Govt. recognized Hospital :

(III) Period of OPD treatment :

(IV) Total No. of original vouchers & money receipts :

(V) Amount claimed for OPD treatment :

Sl. No.	Description of items	Amount Claimed	Amount admissible (for official use)
(a)	Consultation fees (indicate total no. of consultations)		
(b)	Pathological investigations (give Break-up in a separate annexure with code no.)		
(c)	Radiological investigations (attach separate list, if required, with code no.)		
(d)	Medicines (give details of purchase in separate annexure, if required)		
(e)	Special devices like hearing aid/artificial appliances etc. (specify)		

(f) Miscellaneous (specify)

Total

(Rupees: only)

(Signature of Claimant)

Name in Block Letters

Address:

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

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

Counter signed by

(Signature of the Treating Specialist with official seal)

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

(i) Malignant diseases,

(ii) Tuberculosis,

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

(iv) Insulin-dependent diabetes,

(v) Heart diseases,

(vi) Neurological disorders/Cerebrovascular disorders,

(vii) Malignant malaria,

(viii) Renal failure,

(ix) Thallasaemia/Bleeding disorders/Platelet disorders,

(x) Injuries caused by accidents.

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

Maavoi West Bengal Health Scheme for the Journalists, 2016

FORM "D_2"

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist for Indoor/Day Care Treatment and related OPD treatment

1. Name of the Journalist with Press Card No. :

2. Name of Office of the Journalist with address :

3. Name of the patient, relationship with Journalist & Press Card No. :

4. Details of expenditure:

(I) Name of the diagnosed disease :

(II) Name & Code No. of the empanelled/ Government recognized Hospital :

(III)Period of Indoor/Day Care treatment :

(IV)Total No. of original vouchers & money receipts :

(V) Details ofAmount claimed

(A) for Package treatment from _____ to _____ :

Sl No.	Procedure Name	Procedure Code No.	Amount Claimed (Rupees)	Amount admissible (Rupees) (for official use)
(1)	(2)	(3)	(4)	(5)
(i)				
(ii)				
(iii)				
(iv)				
(v)	Miscellaneous (Specify & give details in separate sheet, if necessary)			
		Total=Rupees		

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

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

(VI) Related OPD treatment in terms ofClause-9orClause-7(2)

Sl No. _____ (1)	Description of items (2)	Amount Claimed (Rupees) (3)	Amount admissible (Rupees) (for official use) (4)
(i)	Consultation fees (indicate total no. of consultations)		
(ii)	Charges for : (give details with code nos. in separate annexure)		
(a)	Pathological investigations		
(b)	Radiological investigations		
(c)	Medicines		

(1)	(2)	(3)	(4)
(d)	Special devices like hearing aid/artificial appliances etc. (specify)		
(e)	Miscellaneous (specify)		
Total:		= Rupees _____	_____

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

(Rupees: only)
(in words)

(Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the relevant bills/vouchers have been verified by me as per latest approved rates of the Scheme and the expenditures shown above are correct and the treatment services provided were essential and minimum that required for the recovery of the patient.

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

3. Specific procedure/Operation performed was _____ on _____.

4. Conservative treatment provided from _____ to _____.

(Signature of the Treating Specialist
with official seal)

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

Maavoi West Bengal Health Scheme for the Journalists, 2016

FORM "D3"

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist for treatment services taken from WB Health Scheme non-recognised Private Hospital/ Nursing Home

1. Name of the Journalist with identification No. :

2 Name of Office of the Journalist with address :

3 Name of the patient, relationship with Journalist & identification No. :

4. Details of expenditure:

(I) Name of disease :

(II) Name & Address of the Hospital :

(III) Period of treatment :

(IV) Total No. of original vouchers :

DetailsofAmount claimed:
(give details in separate annexure, if required)

Sl. No.	Description of items	Treatment Period	Amount claimed (Rupees)	Amount Admissible (Rupees) (for official use)
(1)	(2)	(3)	(4)	(5)
(i)				
(ii)				
(iii)				

Maavoi West Bengal Health Scheme for the Journalists, 2016

Sl. No.	Description of items	Treatment Period	Amount claimed (Rupees)	Amount Admissible (Rupees) (for official use)
(1)	(2)	(3)	(4)	(5)
(iv)				
	Total:		Rupees _____	_____

(Rupees: _____ only)
(in words)

(Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the patient had been admitted under my care at _____Hospital/Nursing Home. The Specific procedure/Operation performed was _____ on _____.
2. Certified that the relevant bills/vouchers have been verified by me and the expenditure shown is correct and the treatment services provided were essential and minimum that was required for the recovery/stabilization of the patient.
3. Certified that the treatment was done in an organization having number of beds _____ and having a License under the West Bengal Clinical Establishment Act and Rules bearing no. _____ . The License is valid up to _____.

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

(Signature of the Treating Specialist
with official seal)

FORM E

Checklist for Reimbursement of Medical Claims / Sanction of Advance

1. Journalist Press Card No. & date of enrolment :

2. Full name & designation
   (block letters) :

3. Name of Media House to whom attached
   with address :

4. Whether claim is for the Journalist himself or his beneficiary, if for his beneficiary, mention – :

   a) Name of the beneficiary and relationship with Journalist:
   b) Beneficiary's Identification No. :
   c) Validity of the Card up to :

5. Entitlement of accommodation (Put tick mark) : Semi-Private/General ward

6. Disease :

7. Name of the hospital where treatment was done/to be done /is going on :

8. Whether treatment was done in non-empanelled hospital : Yes/No
   If yes –
   a) Name of the hospital/nursing home with Clinical Establishment licence No. and address :

9. Period of treatment: a) OPD : from _____ to _____

   b) Indoor/ Day Care treatment : from _____ to _____

10. a)Treatment done within the State-

   (i) Copy of intimation letter furnished : Yes/No.

   (ii)Copy of permission letter furnished : Yes/No.
   (For human organ implantation/ Dual-chamber pacemaker/ AICD/ CRT/ more than one drug eluting stents Implantation, etc

   b) Treatment done outside the State –
   Copy of permission letter furnished : Yes/No.

11. (A) Whether the claim for reimbursement has been preferred within

(i) three months from the date of discharge of indoor treatment : Yes/No.
(ii) three months from the date of consultation of OPD treatment : Yes/No.
(iii) three months from the date of purchase of medicines, etc. : Yes/No.
(for continuous OPD treatment)

(B) If not, whether delay in preferring claim has been condoned by the West Bengal Health Scheme Authority under the Finance Department : Yes/No.

12. The following documents are submitted
(please tick [√] the relevant column)

(a) Photocopy of the Health Scheme Identity Card of
I) Journalist : Yes/No.
II) Beneficiary : Yes/No

(b) Essentiality Certificate (as specified) : Yes/No.

(c) Copy of discharge summary : Yes/No.

(d) Copy of OPD prescription : Yes/No

(e) Total Number of original bills & cash memos :

(f) Detailed list/Statement of medicines furnished : Yes/No

(g) Detailed list of investigations furnished : Yes/No

(h) Original papers have been lost the following documents are submitted-

(I) Photocopies of claim papers : Yes/No.

(II) Affidavit on stamp paper : Yes/No.

(III)Photo copy of Police Diary : Yes/No.

(i) In case of death of Journalist following documents are submitted-

(I) Affidavit on stamp paper by claimant : Yes/No.

(II) No objection from other legal heirs on stamp papers : Yes/No.

(III) Copy of death certificate : Yes/No.

Dated.....

Signature of the Applicant