**ANNEXURE-I**

## DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME

## MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. DGEHS Card No. and Place of issue : _____
2. Validity of DGEHS Card : From _____ To _____
3. Ward Entitlement (if Admitted in Hospital) : Pvt. / Semi Pvt. / General
4. Full name of Employee/Beneficiary (Block letters) : _____
5. Designation : _____
6. The following documents are submitted (Please tick (√) the relevant column)

| | | |
|---|---|---|
| a) | Revised Medical Form – 2004 | : Yes / No |
| b) | Photocopy of DGEHS Card showing validity | : Yes / No |
| c) | Photocopy of referral/authorization form from AMA | : Yes / No |
| d) | Original Bills | : Yes / No |
| e) | Copy of prescription for OPD Cases/discharge summary for Indoor Cases | : Yes / No |
| f) | Breakup for Lab Investigation | : Yes / No |
| g) | Breakup for Drugs prescribed | : Yes / No |
| h) | Emergency Certificate from Hospital empanelled /registered with Government in case of emergency admission | : Yes / No |
| i) | Self explanatory letter showing the need of emergency visit (in emergency case) | : Yes / No |
| j) | Non availability certificate from AMA (attached dispensary/Hospital) for drugs prescribed in OPD | : Yes / No |
| k) | If original papers have been lost, the following documents are submitted (if applicable) | |
| | I. Photocopy of claim papers | : Yes / No |
| | II. Affidavit on Stamp Paper | : Yes / No |
| l) | In case of death of card holder, the following documents are submitted (if applicable) | |
| | I. Affidavit on Stamp Paper by Claimant | : Yes / No |
| | II. No objection from other legal Heirs on Stamp Paper | : Yes / No |
| | III. Copy of Death Certificate | : Yes / No |

7. Name of the Bank: _____ Branch _____ SB A/C No. _____

   Branch MICR Code: _____ IFS Code: _____ Tel. No. of Bank Branch _____

Dated: ……

Signature of DGEHS card holder

Tel No. (O) _____

(R) _____

NOTE:

1. Kindly enclose photocopy of cancelled cheque for online transfer of money to the account of beneficiary.
2. Provide one original copy and two photocopies of complete set of claim.

**ANNEXURE-II**

## DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME

## REVISED MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF DGEHS BENEFICIARIES

(To be filled by claimant)

1. DGEHS Card No. and Place of issue : _____

2. Validity of DGEHS Card : From _____ To _____

3. Ward Entitlement (If Admitted in Hospital) : Pvt. / Semi Pvt. / General

4. Full name of Employee/Beneficiary (Block letters) : _____

5. Full address: _____

6. Telephone No.: (O) _____ (R) _____ (M) _____

7. E-mail address, if any : _____

8. Name of the Bank : _____ Branch _____ SB A/C No. _____

   Branch MICR Code _____ IFS Code _____ Tel. No. of Bank Branch _____

9. Name of the patient & relationship with the card holder : _____

10. Basic Pay (excluding Grade Pay) : _____

11. Name of the Hospital with address: _____

    a) OPD treatment (Investigations) & period of treatment : _____

    b) Indoor treatment: Date of admission _____ Date of discharge _____

12.

| Treatment | Consultation Charges | Investigation Charges | Medical Charges | Other Charges | TOTAL |
|---|---|---|---|---|---|
| For OPD Treatment | | | | | |
| For Indoor Treatment | | | | | |
| TOTAL | | | | | |

RESTRICTED AMOUNT: _____

13. Details of Referral: _____

14. Details of Medical advance, if any: _____

### DECLARATION

I hereby declare that 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 DGEHS beneficiary and the DGEHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated: ……  Signature of DGEHS card holder

**Note:** Misuse of DGEHS facilities is a criminal offence. Suitable action including cancellation of DGEHS Card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.