FORM- MRC (P)
*(**For pensioner**)*

CENTRAL GOVERTNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the Principle Card holder/ Claimant in BLOCK LETTERS)

1. (a) Name of the Principle CGHS Card Holder :
   (b) CGHS Ben ID No. :
   (c) CGHS Wellness Center to which the card is attached :
   (d) Validity of CGHS Card :
   (e) Ward Entitlement- Pvt./Semi-Pvt./General :
   (f) Full Address :
   (g) Mobile No. / landline No. / Extension No. :
   (h) E- mail address :
2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principle CGHS card holder :
3. Category of pensioner beneficiary- please specify :
   (Central Govt. Pensioner/ Pensioner of Autonomous/ Statutory body/ Ex. MP/ Ex- Governor/ Former Judge of Supreme Court/ Former Judge of High Court/Freedom Fighter/ Legal Heir/ Others)
4. Name & address of the hospital/ diagnostic center/ imaging center where treatment is taken or tests done :
5. Whether the hospital/ diagnostic center is empaneled under CGHS : Yes/ No
6. Treatment for which reimbursement claimed
   (a) OPD/ Test & Investigations :
   (b) Indoor Treatment :
7. Whether credit facility was availed. If not, Reasons thereof (clarification may be attached) :
8. Whether treatment was taken in emergency : Yes/ No
9. Whether prior permission was taken for the treatment / Details of Medical Advance taken, if any : Yes/ No
10. Whether subscribing to any health/ medical insurance : Yes/ No
11. Total amount claimed
    (a) OPD Treatment
    (b) Indoor Treatment
    (c) Tests/ Investigation
12. Name of the Bank:……. SB A/c No. :……
    Branch MICR Code:……. IFSC Code:……

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

Date: ……..

Place:……..

Signature of the Principle CGHS card holder/ Claimant
Retired form (Name of the lab / Institute)
P.P.O No.
(यह जानकारी भरना आवश्यक है।)

Documents to be attached

1. Photo copy of the CGHS card of the employee along with the patient's CGHS Card.
2. Copy of permission letter, if any.
3. Emergency certificate (original), in case of emergency.
4. Copy of the discharge summary.
5. Ambulance certificate (original), if any
6. Original bills/ cash memo/ vouchers etc. for the reimbursement amount claimed.

IMPORTANT

Kindly ensure to provide the following information/ documents, wherever applicable:

(a) Obtain Break up of Investigations from the hospital/ diagnostic center/ imaging center (details and rates of individual tests and the exact number of tests, X- ray firms, etc.,) as the reimbursement amount is calculated as per approved CGHS rates per tests.

(b) In case of loss of original papers, Affidavits as per Annexure I to be submitted. All photocopies of the bills to be attested by the treating doctor/ specialist.

(c) In case of death of the card holder, Affidavit as per Annexure II to be filled and attached to claim reimbursement.

(d) In case of implants, Invoice No. along with serial number of the implant to be attached.

(e) In case of Coronary Stents, outer pouch of stents is to be enclosed.

(f) In case of replacement of pacemaker/ ICD etc., copy of the warranty certificate of earlier pacemaker/ ICD may be enclosed.

Note: *Misuse of CGHS facilities is a criminal offence. Penal action including cancellation of CGHS card may be taken in case of willful suppression of facts or submission of false statements.*