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भारतीय आयुर्विज्ञान अनुसंधान परिषद
INDIAN COUNCIL OF MEDICAL RESEARCH

वी. रामलिंगस्वामी भवन, अन्सारी नगर, पोस्ट बॉक्स 4911, नई दिल्ली - 110 029
V. RAMALINGASWAMI BHAWAN. ANSARI NAGAR. POST BOX 4911. NEW DELHI - 110 029

No.1/3/2002-Admn.II(CGHS) Dated : 30.10.2014

To

The Directors/Directors-in-Charge
of all perment Institutes/Centres of ICMR.

Sub : Revision of Medical Reimbursement Claim (MRC) Form for CGHS beneficiaries – reg.

Sir/Madam,

Please find enclosed herewith a copy of O.M. No.S.11011/9/2012-CGHS (P), dated the 5th June, 2014 from Ministry of Health & Family Welfare, CGHS (Policy), New Delhi on the subject mentioned above for information and necessary action.

Yours faithfully,

(Bharat Bhushan)
Admn. Officer
For Director-General

No. S. 11011/9/2012-CGHS (P)
Government of India
Ministry of Health & Family Welfare
CGHS (Policy)

Nirman Bhawan, New Delhi
Dated the 5th June, 2014

OFFICE MEMORANDUM

Sub:- Revision of Medical Reimbursement Claim (MRC) Form for CGHS beneficiaries - reg.

The undersigned is directed to state that it has been the constant endeavour of the Ministry of Health & Family Welfare to improve the facilities under CGHS and simplify / liberalize the procedures to make the Scheme user friendly.

2. In furtherance of the above objective, the Medical Reimbursement Claim Form has been reviewed and further simplified. Separate forms have been developed for serving beneficiaries and pensioner beneficiaries with requirement of minimum information required for processing of the claims. The CGHS beneficiaries are required to submit their medical reimbursement claims in the prescribed forms with requisite documentary evidences to their Department / office or CGHS, as the case may be for further processing and settlement as per approved CGHS rates and guidelines.

3. The following forms have been prescribed:

Form MRC(S) – For Serving CGHS beneficiaries,
Form MRC(P) – For Pensioner CGHS beneficiaries.

Specimen Forms are enclosed

Encl: As Above

Admn. II

[V.P. Singh]
Director
Telefax: 2306 1831

To

1. All Ministries / Departments, Government of India
2. Director, CGHS, Nirman Bhawan, New Delhi
3. Addl.DDG(HQ), CGHS, MoHFW, Nirman Bhawan, New Delhi
4. AD(Hq), CGHS, Bikaner House, New Delhi
5. All Additional Directors /Joint Directors of CGHS cities outside Delhi
6. Additional Director (SZ)/ (CZ)/(EZ)/(NZ), CGHS, New Delhi
7. JD(HQ)/JD (Gr.)/JD(R&H)/(MSD), MCTC, CGHS Delhi
8. CGHS –I/II/III/IV, Dte. General of CGHS, Nirman Bhavan, New Delhi
9. Estt.I/ Estt.II/ Estt.III/ Estt.IV Sections, MoHFW, Nirman Bhawan, New Delhi
10. MS Section, MoHFW, Nirman Bhawan, New Delhi
11. Admn.I / Admn.II / MG Sections of Dte.GHS, Nirman Bhawan, New Delhi

Contd.....2/-

FORM – MRC (S)
(For serving employees)

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the Principal Card holder in **BLOCK LETTERS**)

1. (a) Name of the Principal CGHS Card Holder :
   (b) CGHS Ben ID No. :
   (c) Employee Code No. :
   (d) Ward Entitlement – Pvt./Semi-Pvt./General :
   (e) Full Address :

   (f) Mobile telephone No. and e-mail address, if any :

2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal CGHS card holder :

3. Name & address of the hospital / diagnostic center / imaging center where treatment is taken or tests done:

4. Whether the hospital/diagnostic/imaging center is empanelled under CGHS : Yes/No

5. Treatment for which reimbursement claimed
   (a) OPD Treatment /Test & investigations :
   (b) Indoor Treatment :

6. Whether treatment was taken in emergency : Yes/No

7. Whether prior permission was taken for the treatment : Yes/No

8. Whether subscribing to any health/medical insurance scheme, If yes, amount claimed/received : Yes/No

9. Details of Medical Advance taken, if any :

10. **Total amount claimed**
    (a) OPD Treatment :
    (b) Indoor Treatment :
    (c) Tests/Investigation :

11. 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.

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 films, etc.,) as the reimbursable amount is calculated as per approved CGHS rates per test.

b) In case of loss of original papers, Affidavits as per Annexure I to be submitted. All photocoples 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,

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

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

e) 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. Suitable disciplinary action shall be taken in case of serving employees.*

Annexure –I

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper

I, ... son / wife / daughter of.....and resident of .....have lost / misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim papers from any source and that if the original papers are traced, I shall not stake claim against original bills in future and that in the event, I receive any cheque against the original bills in future, I shall return the same to competent authority.

Deponent

Verified by Notary Public

FORM – MRC (P)

(For pensioner beneficiaries)

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled by the Principal Card holder/Claimant in **BLOCK LETTERS**)

1. (a) Name of the Principal 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 telephone No. and e-mail address, if any :
2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal 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/imaging center is empanelled 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 : Yes/No

10. Whether subscribing to any health/medical insurance : Yes/No
    scheme, If yes, amount claimed/received :
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.

Documents to be attached

1. Photo copy of the CGHS card of the principal card holder 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 films, etc.,) as the reimbursable amount is calculated as per approved rates per test.

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,

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

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

e) 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 claims / statements.

Annexure –I

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper

I, ... son / wife / daughter of.....and resident of .....have lost / misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim papers from any source and that if the original papers are traced, I shall not stake claim against original bills in future and that in the event, I receive any cheque against the original bills in future, I shall return the same to competent authority.

Deponent

Verified by Notary Public

Annexure – II

Draft for Affidavit on Stamp Paper for claiming medical reimbursement IN CASE OF DEATH of a CGHS Card Holder

I,.....husband / wife / son / daughter of Late..... and resident of ....., hereby submit the medical reimbursement claim papers pertaining to treatment of my husband / wife / father / mother Late Shri/ Smt.....who has expired on ..... *(copy of Death Certificate is enclosed).*

Late Shri/Smt.....has left behind the following other legal heirs, none of whom have any objection if the entire reimbursable amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp paper is enclosed.

Deponent

Attested by Notary Public

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Draft for No Objection Certificate on Stamp Paper.

We (i)..... S/o D/o Late Shri.....
(ii)..... S/o D/o Late Shri.....
(iii)..... S/o D/o Late Shri.....
(--) .....
(--) .....
(--) .....

being the legal heirs of Late Shri/Smt.....have no objection if the entire amount reimbursable pertaining to the treatment of late Shri / Smt .....is paid to Shri / Smt .....

(i) (Signature) Name: Address:	(ii) (Signature) Name Address:	(iii) (Signature) Name: Address
(iv).....	(v).....	(vi).....

Verified by Notary Public