Manual/ Offline Reimbursement Application Form

Form -C1

Reimbursement for cost of Out-Door Patient (OPD) treatment in Empanelled /Enlisted Hospital

under West Bengal Health Scheme

(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)

Part-I[General Information]

1. Details of Employee/Pensioner.			
Full Name (in Block letters)		HRMS ID / PPO No.	
Enrollment 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 and Condonation Requirement, if any.		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes ☐ No☐ Not known☐

3. Details of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details, If any		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in enlisted hospital outside West Bengal *(see clause 14 of order no.7287, dated 19.09.2008*).	Memo No. : Date: Designation / Authority : U.O. No. and dateof Finance Deptt. West Bengal, if any:

Part-II [Details of Expenditure Statement of OPD treatment]

5. Details of OPD Treatment					
Sl. No.	**Particulars**	**Details**			
5.1	Category of OPD Claim (Tick mark in appropriate box)*[See list of diseases/illness mentioned in clause 7(1) and 7(2)]*	As per clause 7(1) of OPD List	☐	As per clause 7(2) of OPD List	☐
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment				
5.3	Date of OPD consultation				

6. Expenditure Statement of OPD treatment		
Sl.	Name of Components	Amount

No.						Claimed (Rs.)
6.1	Consultation Fees					
6.2	Cost of Pathological and Radiological Investigations					
6.3	Cost of Medicines					
	Period of medicine consumption	From		To		
6.4	Cost of Special Device					
6.5	Miscellaneous (specify)					
					Total	
					No. of Vouchers	

Part-III [Medical Advance]

7. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: *[Part-II minus Part III] or [Part-II minus Part-III plus Part IV]*	
Rs. ;	In words; Rupees

Part-V [Declaration of Employee/Pensioner]

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

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	**Annexure-I** duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital	Yes ☐	No ☐
2	Enrollment Certificate of beneficiary	Yes ☐	No ☐
3	Money Receipts in sequentially	Yes ☐	No ☐
4	Copy of OPD Prescription	Yes ☐	No ☐
5	Copy of permission granted if any	Yes ☐	No ☐
6	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes ☐	No ☐
7	Copy of all investigation/ test reports in sequentially.	Yes ☐	No ☐

8	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
9	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
10	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Employee/Pensioner/Claimant:
Name in Block Letters :
Designation/Last Designation :