Manual/ Offline Reimbursement Application Form

Form –C2

Reimbursement for cost of In-Patient Department (IPD) treatment in Non-Empanelled 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 end the Head of Office)*	

2. Detail of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Non-Empanelled/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. Detail of Claimant *(Applicable in case of death of employee or pensioner or family pensioner)*

Sl. No.	Name of claimant	Relation
3.1		

Part-II [Details and Expenditure Statement of IPD treatment]

4. Period of treatment					
Admission Date			Discharge Date		
5. Type of Discharge					
Sl. No.	Type of Discharge	Tick mark in appropriate box	Sl. No.	Type of Discharge	Tick mark in appropriate box
5.1	Normal	☐	5.3	Referral	☐
5.2	Risk Bond	☐	5.4	Death	☐

6. Amount Claimed for		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	☐
6.2	Only Non- Procedural/ Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	☐

6.1 Details of Procedural/ Package Treatment				
Period of Procedural/ Package Treatment		From		To
Sl. No	Name of Procedures/ Packages			Amount Claimed (Rs.)
6.1.1				
6.1.2				
6.1.3				
6.1.4				

6.1.5		
	Total	

6.2 Details of Implants Used		
Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment					
Period of Non-Procedural/ Package Treatment		From		To	
Sl. No.	Name of Components				Amount Claimed (Rs.)
6.3.1	Room/ Bed Rent				
	ICCU/ITU/ICU/NICU/PICU	From		To	
	HDU/SDU	From		To	
	Burn Unit	From		To	
	CRIB	From		To	
	General/Semi-Private/Private	From		To	
6.3.2	Consultation Fees				
6.3.3	Pathological and Radiological Investigations				
6.3.4	Medicines				
6.3.5	Consumables				
6.3.6	Special Nursing/Aya Charges				
6.3.7	Miscellaneous. (If Any Specify)				
	Total				
	No. of Vouchers				
	Total Treatment Cost [6.1+ 6.2+6.3]				

Net Claim:*(Part-II)*	
Rs. ;	In words; Rupees

Part-III [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.	Name/Particulars of enclosures to be attached	Enclosed or not

No.			
1	**Annexure-II** duly signed with proper stamp by the Medical Superintendent of a Non-Empanelled Hospital	Yes ☐	No ☐
2	Enrollment Certificate of beneficiary	Yes ☐	No ☐
3	Bill Summary	Yes ☐	No ☐
4	Money Receipts in sequentially	Yes ☐	No ☐
5	Copy of Discharge Summary (Case summary in case of death) and OT note and copy of death certificate	Yes ☐	No ☐
6	Detailed Bill	Yes ☐	No ☐
7	Original copy of Voucher/ Tax Invoice/ Challan of Implants	Yes ☐	No ☐
8	Copy of all investigation/ test reports in sequentially	Yes ☐	No ☐
9	Copy of OT Note in case of procedural/package treatment and treatment summary or bed head ticket in case of non-procedural/package treatment	Yes ☐	No ☐
10	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☐
11	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
12	Any other instruments (Specify)	Yes ☐	No ☐

Date:

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