DELHI GOVT. EMPLOYEES HEALTH SCHEME
REVISED MEDICAL 2004 FORM FOR REIMBURSHMENT
MEDICAL CLAIMS OF DGEHS BENEFICIARIES

(To be filled by the claimant)

1. DGEHS Card No. and place of issue:
2. Validity of DGEHS and Entitlement Date:..... & Semi/Private/General
3. Full name of Employer/Beneficiary (Block Letter):
4. Full Address:_____
   _____
5. Telephone No.
   (o) _____ (R)_____(M)_____
6. E-mail Address if, any
7. Name of the Bank_____ _____Branch_____SB A/C_____
   Branch MICR Code.....Tel. No. of Bank Branch.....
8. Name of the patient & relationship with the card holder
9. Basic Pay (excluding Grade Pay) _____
10. Name of the Hospital with Address:.....
    (a) OPD treatment (investigations) & period of Treatment
    (b) Indoor Treatment.....
11. Date of Admission _____ Date of Discharge (in case Of Indoor Treatment Only)
12. Total amount Claimed
    (a) OPD Treatment
    (b) Indoor Treatment
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 dependant 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.

DELHI GOVT. EMPLOYEES HEALTH SCHEME
MEDICAL CHECK FOR REIMBURSEMENT OF MEDICAL CLAIM

1. DGESH Card No. and place of issue:
2. Validity of DGESH Card & Entitlement Date:..... & Semi/Private/General
3. Full name of Employee/Beneficiary (Block Letter)
4. Designation
5. The following documents are submitted
   (Please tick ( ) the relevant column)

(a)	Revised Medical 2004 Form	Yes/No
(b)	Photocopy (s) of DGEHS Card (Emp./Patient)	Yes/No
(c)	Photocopy of permission letter	Yes/No
(d)	Original Bills	Yes/No
(e)	Copy of prescription/discharge summary	Yes/No
(f)	Copy of referral by Govt. Specialist/CMO	Yes/No
(g)	Breakup for lab. Investigations	Yes/No
(h)	Self explanatory letter (in emergency cases)	Yes/No
(i)	Original papers have been lost me following documents Are submitted:-	
	(a) Photocopies of claim papers	Yes/No
	(b) Affidavit on Stamp Paper	Yes/No
(j)	Incase of death of card holder the following document Are submitted:-	
	(a) Affidavit on Stamp Paper by Claimant:	Yes/No
	(b) No objection from other legal Heirs on Stamp Paper	Yes/No
	(c) Copy of death Certificate	Yes/No

Dated:-.....

Signature of DGEHS Card holder
Tel. No. (o)
(R)
e-mail Address

Name of the Bank..... Branch.....SB A/C No.....
Branch MICR Code.....Tel. No. of Bank Branch.....

TREATMENT SUMMARY FORM

(to be filled by the claimant)

[Detail of OPD charges/Room Rent/Consultations/Procedure (Nursery/Medicine charges (name and Quantity of Medicines/Medical Tests/Physiotherapy charges etc.]

S. No.	Detail of Medical Treatment Availed (in capital letters only)	Amount (in Rs.)	Amount Restricted (if any)
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
___	_____	_____	_____
	TOTAL CLAIM :-	_____	_____

(Signature)_____

Name & Designation:_____