



NATIONAL HEALTH MISSION, ASSAM



MEDICAL REIMBURSEMENT CLAIM FORM

Form of application for claiming refund of medical expenses incurred in connection with medical attendance and/ or treatment of **National Health Mission (NHM), Assam** Employees and their families for medical attendance/treatment taken from an Authorized Medical Attendant/ Hospital.

(NB: SEPARATE FORM SHOULD BE USED FOR EACH PATIENT)

1. EMPLOYEE DETAILS:

- HRMIS ID :
- NAME (in Block Letters) :
- Designation :
- State Level / District Level :
- Date of Joining under NHM (dd/mm/yyyy) :
- Original Place of Posting:
- Present Place of Working :
(If attached, place of working & enclose attachment order)
- Current Remuneration per month :
- Present Address :
- Permanent Address :
- Mobile No. :
- Marital Status (✓ tick mark) : (Single / Married / Widowed / Divorced / Separated)

2. PATIENT INFORMATION:

- Name of the Patient :
- Relationship to the NHM Employee :
- Age of the Patient :
- Medical Problem :
- Claim submitted for Regular/ Emergent, Accident in Empaneled/ Non-Empaneled :
- Whether the patient a Govt./ Retired Govt. employee (✓ tick mark) : (Yes / No)
(If Yes, Office/ Division in which employed)

3. CLAIM DETAILS:

- Whether the Patient covered under AAA/ PMJAY? (✓ tick mark) (Yes / No)
If Yes, Registration No. :
- Where the patient fell ill / met accident ?
- Whether any Medical Reimbursement Claim submitted in the current Financial Year? (✓ tick mark)
(Yes / No)
- Whether Re-imburement/ Advance ?:

4. MEDICAL ATTENDANCE:

(i) Fees for consultation indicating :

- (a) The name & designation of the medical Officer consulted and the hospital or dispensary to which attached :
- (b) The number and dates of consultation and the fee paid for each consultation :
- (c) The number & dates of injection and the fee paid for each injection :
- (d) Whether consultation and/or injections were had at the hospital, at the consulting room of the medical officer or the residence of the patient :

(ii) Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating :

- (a) The name of the hospital or laboratory where undertaken, and :
- (b) Whether the tests were undertaken on the advice of the authorised medical attendant :
If so, a certificate to that effect should be attached

(iii) Cost of medicine purchased from the market :
(list of medicines, cash memos and the essentiality certificates should be attached)

- Name of the Hospital where treatment done _____

Charges for hospital treatment indicating separately the charges for :-

- (i) Accommodation :
- (ii) Diet :
- (iii) Surgical operation or medical treatment or confinement :
- (iv) Pathological, bacteriological, radiological or other similar tests indicating :
 - (a) The name of the hospital or laboratory at which undertaken; and :
 - (b) Whether undertaken on the advice of the :

medical Officer-in-charge of the case at the hospital. If so, a certificate to that effect should be attached.

(v) MEDICINES

(vi) Special medicines (list of medicine, cash memos and the essentiality cash should be attached) :

(vii) Ordinary Nursing :

(viii) Special nursing i.e. nurses, specially engaged for the patient. State whether they are employed on the advice of the medical Officer-in-charge of the case at the hospital or at the request of the NHM Employee or patient. In the former case a certificate from the medical Officer-in-charge of the case and countersigned by the medical superintendent of the hospital should be attached :

(ix) Ambulance charges (state the journey to _____ and from _____ undertaken) :

(x) Any other charges, e.g. charges for electric light, fan, heater, air conditioning, etc. :

State also whether the facilities referred to are a part of the facilities normally provided to all patients and no choice was left to the patient

III. CONSULTATION WITH SPECIALIST

Fees paid to a specialist or a Medical Officer other than the authorised medical attendant indicating :-

a) The name and designation of the specialist or medical officer consulted and the hospital to which attached :

b) Number and dates of consultation and the fees charged for each consultation :

c) Whether consultation was had at the hospital, at the consulting room of the specialist or Medical officer, or at the residence of the patient :

d) Whether the specialist or Medical Officer was consulted on the advice of the authorised medical attendant and the prior approval of the Chief Administrative Medical Officer of the State was obtained. If so, a certificate to that effect should be attached :

NOTE: FILL ONLY APPLICABLE PART I &/OR II &/OR III

- Total Amount Claimed Rs. _____
- Less Advance Taken on Rs. _____
- Net Amount Claimed Rs. _____
- List of enclosures Rs. _____

DECLARATION TO BE SIGNED BY THE EMPLOYEE:

I hereby declare that the statements in the application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me. In case of any false statement, I understand the amount may be released from me with interest and I would be liable for any disciplinary action.

Dated: _____

(Signature of Employee)

(Signature of Authority)

Name:

Name:

Contact No.:

Designation:

E-mail Address:

FOR OFFICE USE ONLY:

We have examined the claim submitted byand found the facts true. We confirm the claim is genuine and recommend payment of **Rs**..... for medical reimbursement as per provision of Office Memorandum (No. *NHM-31016/2/2019-HRD-NHM/26941 dated 09/01/2020*).

District Admissibility Board Members:

(1)

(2)

(3)

(4)

❖ **APPLY FOR MEDICAL REIMBURSEMENT:**

To apply for medical reimbursement, the applicant should submit the medical reimbursement proposal along with the following information:

DOCUMENT CHECKLIST:

➤ **For NHM Employee posted at District:**

Recommendation from **District Level Admissibility Board** (seal & signature of the Members along with Admissible amount by name of incumbent concerned is mandatory to furnish along with the Admissibility Report).

Checklist:

- Minutes of the meeting / Check List of the District Level Admissibility Board (seal & signature of the Members alongwith Admissible amount by name of incumbent concerned is mandatory to furnish along with the Admissibility Report)
- Admissibility Report from the Jt. Director of Health Services (concerned district).
- Authorized Medical Attendants recommendation (if applicable).
- Referral Medical Board's Certificate
- Essentiality Certificate.
- Discharge Summary/Certificate.
- Records of Hospital, if applicable
- Certificate from the Hospital authority.
- Final bill / Bill summary issued by the Hospital authority.
- Attested copy of Bank Pass Book.
- Birth / Death Certificate (if applicable).
- NOK / Legal Heir Certificate (if applicable).
- Original bills/vouchers etc.
- Leave order for the treatment period (if applicable).
- A self declaration / undertaking of no claim from other sources.
- Dependent certificate from concerned authority (if applicable).
- Physical Verification Certificate of concerned D.D.O.

➤ **For NHM Employee posted at State HQ:**

Recommendation **State Admissibility Board** (Seal & Signature of the Members along with Admissible amount by name of incumbent concerned is mandatory to furnish along with the Admissibility Report).

- Authorized Medical Attendants recommendation (if applicable).
- Referral Medical Board's Certificate.
- Essentiality Certificate/ Identity proof of the patient along with documents showing relation with the NHM Employee.
- Discharge Summary/ Certificate.
- Certificate from the Hospital Authority.
- Final Bill / Bill summary issued by the Hospital Authority.
- Attested copy of Bank Pass Book.
- Birth / Death Certificate (if applicable).
- Original Bills to be submitted with Seal & Signature for applying medical reimbursement.
- Leave order for the treatment period (if applicable).
- A Self Declaration / Undertaking of no claim from other sources.
- Dependent Certificate from concerned authority (if applicable).
