ANNEXURE-I

DELHI GOVERNMENT HEALTH SCHEME
MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS
(Claim should be submitted in duplicate)

1. DGHS Token/CARD No. and place of issue :
   (or Ben ID of Employee/Pensioner)
2. Validity of DGH Card (For pensioners)& : from………… ……to…… …..…….

   Entitlement : Pvt. / Semi Pvt./ General:

3. **Full name & designation** of Card Holder/MLA (Block Letters) :
4. **Status** (Govt. Servant/Pensioner/MLA/Other) :
5. The following documents are submitted :

{Please tick (√) the relevant column}

(a) Medical 2004 Form : Yes/ No

(b) Photocopy of DGHS card : Yes/ No.

(c) No. of Original Bills : …………

(d) Copy of discharge summary : Yes/ No.

(e) Copy of referral Specilaist/CMO : Yes/ No.

(f) Whether the hospital has given breakup : Yes/ No.
for lab investigations

(g) Original papers have been lost the
following documents are submitted—

I. Photocopies of claim papers : Yes/ No

II. Affidavit on Stamp Paper : Yes/ No.

(h) Incase of death of card holder the
following documents are submitted----

I. Affidavit on Stamp paper by
Claimant : Yes/ No.

II. No objection from other legal
Heirs on Stamp papers : Yes/ No.

III. Copy of death certificate : Yes/ No.

Dated:………………….. **Name & Signature of DGHS card holder/MLA/MMC**

Tel. No. (O)………………………….(R)………………………….

e-mail Address……………………………………………………..

Name of the Bank …………. ……………….… Branch……………………..……..

SB A/C No…………………………………………….

Branch MICR Code ………….…………. Tel. No. of Bank Branch………………..

DELHI GOVERNMENT HEALTH SCHEME
MEDICAL 2004 FORM FOR REIMBUREMENT OF MEDICAL CLAIMS OF DGHS BENEFICIARIES.(Claim papars to be submitted in duplicate)

(To be filled by the claimant)

1. DGHS Token No. and Place of issue :
   (or Ben ID of Employee/Pensioner)
2. Validity of DGHS Token Card : from…………..………to………….………
   & **entitlement :** **Pvt. / Semi Pvt. /General**
3. **Full name** of the card holder/MLA(Block Letters) :
4. **Full address** :
5. Telephone no. (O)………………… (R) …………………..
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 :……………………………………………………
   Age & date of birth in case of son :………………………………..…………….
9. **Status tick** (√) (**Govt. Servant/Pensioner/MLA/Ex-MLA/Ex-MMC**)

10. Basic Pay/Basic Pension:

11. **Name of the Hospital with Address**:

(a) **OPD treatment and investigations**& period of treatment:…………………..……….

(b) **Indoor Treatment**: Date of admission……………………Date of discharge…………….

12.Total amount claimed	Consultation charges	Investigation charges	Medicine charges	Other charges	GRANT TOTAL
For OPD treatment					
For Indoor Treatment					

13. Details of Referral :…………………………………………………

14. Details of Medical advance if, any:…………………………………….

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 dependant on me. I am a DGHS beneficiary and the DGHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated: **Signature of DGHS card holder/MLA/Ex-MLA-MMC**

Note: Misuse of DGHS facilities is a criminal offence. Suitable action including cancellation of DGH 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.

INFORMATION:

a) Kindly write correct postal address in block letters

b) **Obtain Break up of Investigations from the hospital (details and rates of individual tests and the exact number of Sugar tests, X-ray films, etc.,) as the reimbursable amount is calculated as per approved rates only.**