FORM -MRC (S) (For serving employees)

CENTRAL GOVERNMENT HEALTH SCHEME
MEDICAL REIMBURSEMENT CLAIM FORM
(To be filled up by the Principal Card holder in BLOCK LETIERS)

1. (a) Name of the Principal CGHS Card Holder & Designation :
   (b) CGHS Ben ID No. :
   (c) Employee Code No. :
   (d) Ward Entitlement -Pvt./Semi-Pvt./General :
   Basic Pay (excluding Grade Pay) :
   (e) Full Address

   (f) Mobile telephone No. and e-mail address, if any:

2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal CGHS card holder :

3. Name & address of the hospital/ diagnostic centre / imaging centre where treatment is taken or tests done:

4. Whether the hospital/diagnostic imaging centre is empanelled under CGHS :

5. Treatment for which reimbursement claimed :
   (a) OPO Treatment /Test & investigations
   (b) Indoor Treatment

6. Whether treatment was taken in emergency :

7. Whether prior permission was taken for the treatment:

8. Whether subscribing to any health/medical insurance scheme, If yes, amount claimed/received :

9. Details of Medical Advance taken, if any :

10. Total amount claimed
    (a) OPO Treatment
    (b) Indoor Treatment
    (c) Tests/Investigation
11. Name of the Bank: _____ SB A/C No.: _____
    Branch MICR Code _____ IFSC Code _____

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

Date:

Place: **Signature of the Principal CGHS card holder**