

FORM D**Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist**

(See sub-clause (3) of clause 12)

(to be submitted in duplicate)

(Strike out whichever is not applicable)

1. Name of the patient and relationship :
with Govt. Employee

2. Details of expenditure :

(A) OPD TreatmentDiagnosis

(I) Name of the Hospital :

(II) Total No. of vouchers :

(III) Amount claimed :

(Indicate serial number of individual vouchers with name and address of the shops with date against each sub-heading in a separate annexure wherever required)

	Amount Claimed	Amount admissible (for official use)
(a) Medicine		
(b) Consultation fees		
(Specify number of consultations)		
(c) Laboratory charges		
(Break-up in a separate annexure)		
(d) Disposable surgical Sundries		
(e) Special devices like hearing aid/artificial appliances etc. (specify)		
(f) Miscellaneous (specify)		

Total :

(B) Indoor TreatmentDiagnosis

(To be marked N.A. wherever necessary)

(Details of Hospital Bill and other vouchers pertaining to the period of indoor treatment)

- (a) Name of the Hospital with :
address
- (b) Period of Bill : From _____ To _____
- (c) Amount claimed
(indicate serial number of individual vouchers with name and address of shops with date against each sub-heading in a separate annexure wherever required)

	Amount Claimed	Amount admissible (for official use)
(i) Room Rent : (ICU/ICCU/Ward) From _____ To _____		
(ii) Charges for :		
(a) O.T.		
(b) O.T. Consumables		
(c) Anesthesia		
(d) Procedure		
(iii) Medicines		
(iv) Implants like pacemaker, Joint Replacement, coronary stent etc. (details)		
(v) Artificial devices (details)		
(vi) Lab Charges (Break-Up given in Annexure)		
(vii) Spl. Nurse/Ayah, if any		
(viii) Miscellaneous		
Total :		

(Signature of Claimant)

Name in Block Letters

Address :

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1. Certified that the relevant bills/vouchers have been verified by me and the expenditure shown above is correct and the treatment services provided are essential and minimum that required for the recovery of the patient
 2. Certified that the services of Special Nurse/Ayah were required from _____ to _____ that were absolutely essential for the recovery of the patient.
 3. Specific procedure/Operation performed was _____

*(Signature of the Treating Specialist
with official seal)*

Countersigned by Medical Superintendent
of the Hospital with seal
(For Indoor treatment only)

FORM E

Checklist For Reimbursement of Medical Claims

(See sub-clause (3) of clause 12)

1. Card No. and place of issue :
2. Entitlement : Private/Semi-Private/General ward
3. Full name of Card Holder Govt. employee (block letters) :
4. Designation :
5. The following documents are submitted (please tick [✓] the relevant column) :
 - (a) Photocopy of the identity : Yes/No.
 - (b) Essentiality Certificate : Yes/No.
 - (c) Number of original bills :
 - (d) Whether original bills/vouchers have been verified : Yes/No.
 - (e) Copy of discharge summary : Yes/No.
 - (f) Copy of permission letter : Yes/No.
 - (g) Whether the hospital has given break up for lab investigations : Yes/No.

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

(I) Photocopies of claim paper : Yes/No.

(II) Affidavit on stamp paper : Yes/No.

(i) In case 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.....

Signature of the Applicant

Form - F

Temporary Family Permit

[See sub-clause (9) of clause 10]

1. Name of the Govt. employee :
2. Employee code No. (GPF No.) :
3. Designation :
4. Present Pay (Basic pay+Dearness Pay) :
5. Entitlement of accommodation :
6. Date of birth :
7. Date of Superannuation :
8. Residential address :
9. Details of Family :

SI. No.	Name	Age	Relationship	Monthly Income, if any.
1.				
2.				
3.				
4.				
5.				

Shri/Smt. attached to(office) under
..... Department has been enrolled under the West Bengal Health Scheme, 2008 with
effect from

He/She and his/her family members are entitled to the medical attendance and treatment in a Govt. Hospital/
enlisted Pvt. Hospital or Institution etc. in the entitled class mentioned in SI. No.5

This permit is valid for 6 (six) months from the date of issue.

Signature of Cadre controlling authority/Head of the office.

By order of the Governor,

D. MUKHOPADHYAY,
Principal Secy. to the Govt. of West Bengal.