

REIMBURSEMENT OF MEDICAL EXPENDITURE IN RESPECT OF ESI BENEFICIARIES

1. Name of the Insured Person :
2. Name of the patient :
3. Insurance No. :
4. Name of the employer / company :
5. Relation with the IP :
6. Whether the case was referred : YES / NO (Tick whichever is applicable)
7. If referred, then referral letter No. :
(copy/original letter enclosed)
8. Referred by :
9. Name of the hospital to which referred :
10. Whether Hospitalized : YES / NO (Tick whichever is applicable)
11. If hospitalized, period of stay :
12. Diagnosis / details of Treatment / Procedure done :
13. Whether the medicines available in the Store : YES / NO (Tick whichever is applicable)
14. Cost of the treatment
 - a) Amount paid to the hospital :
 - b) Amount paid other than to the hospital :
(Blood / Ambulance / Test / Medicine)
15. Total Amount claimed :
16. Eligibility of the IP / Family :
17. Bank Details
 - a) Name of the Bank :
 - b) Name of the Branch :
 - c) S. B. Account No. :
 - d) IFS Code No. :
(Please enclose cancelled cheque /
photocopy of bank passbook)
18. Whether Statement I & II attached
in the prescribed proforma : YES / NO (Tick whichever is applicable)
19. Mobile No. :

UNDERTAKING

I, Sri/Smt. _____ aged about _____ years W/o S/o D/o _____ Insurance No. _____ attached to ESI Dispensary / Hospital _____ working as a _____ of _____ at _____ PO: _____ in the district of _____ is hereby declare / undertake as follows :

- 1) That, I have not received any claim from employer / STF / BKKY / RSBY / BSKY and any other health insurance agencies.
- 2) That, if the claim amount will be detected false in future the same will be recovered from me or my legal heirs.
- 3) That, if a claim will be considered as per CGHS package rate / AIIMS rate, the same will be accepted by me.

Date :

Full Signature of the I.P.

Countersignature of IMO I/c. /
Superintendent / Joint Director-Cum-Superintendent

FOR OFFICE USE

20. Name of the Hospital / Dispensary :
21. Whether IP is entitled for the benefit :
22. Amount claimed :
23. Amount disallowed :
24. Amount recommended for sanction :

Scrutinized by
(Seal with signature)

Signature of IMO I/c.

ESSENTIALITY CERTIFICATE

It is to certify that Sri/Smt./Kum.

Son/Daughter/Father/Mother/Wife of Sri/Smt./Kum.....serving

as under the Department/Office of
the M/s.....has been under my treatment for

..... from to at my consulting /
Room / Residence of the Patients/Indoor/Outdoor of

..... Hospital/Dispensary/RHC/NAC and the under mentioned
medicines were essentially necessary for the prevention of the serious deterioration of the patient.

The medicines do not include any of the items in the list of inadmissible medicines and similar
preparationreimbursing the cost of which is inadmissible to Govt. Servants and their family members.

Sl. No.	Name of the Medicine	Qty.	Bill No.	Bill Date	Amount (In Rs.)

(N.B. The name of the Medicine or the name of the disease should be written in CAPITAL LETTERS)

Encl. Original Bills

Signature of the AMA with his Seal

I Certify that I was not on leave or under suspension or on deputation to Foreign Service during the period
of treatment referred to in the above essentiality certificate.

Signature of the AMA with his seal

Signature of the IP Attested

Check list for submission of reimbursement claim of ESI beneficiaries

Sl. No.	Documents	Check Box (Please tick the boxes, if submitted)
(1)	(2)	(3)
1.	Signature of the I.P. (Insured Person) should be attested in e-pehchan card by the employer and authority of the concerned ESI Hospital / Dispensary.	
2.	Eligibility certificate of I.P. covering the treatment period from Branch Manager, Branch Office, ESI Corporation	
3.	The Identity of the patient should be verified by the treating physician / IMO In-charge / Superintendent / Joint Director (Aadhar Card / Voter ID card & ESIC e-pehchan card). In case of direct admission, emergency certificate from the treating physician is required.	
4.	Discharge certificate from the treating hospital in original with signature & seal along with the signature of the IP duly attested, with a seal of the treating hospital should be furnished.	
5.	Discharge Certificate from the treating hospital in original with signature and seal of the treating physician as well as seal of the treating institution.	
6.	In case of death, the copy of the Death Certificate, Legal Heir Certificate in original, of the deceased IP is required.	
7.	Statement-I & Statement-II should be attached mentioning admissible and non-admissible amount. The recommended amount towards reimbursement should be attested by the concerned authority of the attached hospital / dispensary.	
8.	Undertaking of IP regarding acceptance of claim, if considered as per CGHS rate, non-receipt of any claim from the employer, S.T.F./R.S.B.Y./B.K.K.Y./ B.S.K.Y. and any other health insurance agencies and if the claim amount detected false in future, the same will be recovered from the IP / legal heir of the IP concerned.	
9.	In case of out-patient treatment out of stock certificate (O.S. certificate) by concerned dispensary / hospital with seal & signature is required for sanction.	
10.	Bank details containing A/c. number, IFSC, MICR No., front page of the Bank Passbook / Cancelled cheque for payment through ECS.	

11.	In-case of out-patient treatment out-of-stock certificate (O.S. Certificate) by the concerned dispensary / hospitals with seal and signature of the authority is required for sanction.	
12.	In case of direct admission, whether the IP has intimated to the nearby ESI Hospital / Dispensary, within 48 hours of admission.	
13.	Reimbursement claim bill should be verified as per CGHS rate / CGHS package rate / ESIC Medical Manual and financial guidelines with reference to the procedure followed as mentioned in the discharge summary.	
14.	GST No. of the medicine store should be mentioned in the invoice / bill with seal and sign of the concerned authority. Original prescription bills / invoice / payment receipt, etc. of the hospital should be attached in chronological order.	
15.	The IP should have to submit the RCM claim within one year from the date of treatment to avoid time barred relaxation.	
16.	Name of the patient, date, quantity and price should be checked properly and any over writing will be disallowed.	
17.	In case of any implant / orthopaedic appliances to be mentioned item-wise towards money receipt mentioned in GST number of the institution.	
18.	Indoor treatment in any private hospital, final bill is required along with seal and signature of the treating physician and treating institution.	
19.	In case of any investigation report should be attached with seal and signature of the concerned hospital.	
20.	Reimbursement of conveyance charges incurred by IP where ambulance or any other transport under the scheme is not available owing to some reasons or the other and where in the opinion of the IMO / IMP such a patient was non-ambulatory.	
21.	Page marking should be marked on all documents.	

COPY OF DOCUMENTS TO BE SUBMITTED BY THE I.P.

Sl. No.	Particulars	:	
1.	Name of the patient	:	
2.	Relation / Name of the Insured Person	:	
3.	Insurance Number	:	
4.	Name of the Hospital / Dispensary attached	:	
5.	Copy of e-pehchan card / TIC	:	
6.	Disease	:	
7.	Name of the treating hospital	:	
8.	Period of treatment	:	
9.	Referred / direct admission	:	
10.	Identification of patient by treating physician on photo copy of e-pehchan card / TIC in case of direct admission.	:	
11.	Eligibility Certificate covering treatment period	:	
12.	Essentiality certificate duly signed by treating physician	:	
13.	Statement-I & II signed by JD-cum-Supdt./Supdt./ IMO I/c.	:	
14.	Final bill of treating hospital in case of indoor treatment	:	
15.	Original bills with prescription, tax invoice with money receipts / original discharge certificate	:	
16.	Bank details with IFSC code	:	
17.	Death certificate in case of death of IP	:	
18.	Legal heir certificate in case of death of IP	:	
19.	No objection certificate from children above 18 years, in undertaking.	:	
20.	Amount claimed by IP	:	
21.	Amount suggested for sanction by hospital / dispensary as per CGHS rate.	:	
22.	Amount recommended for sanction	:	

Name of the patient : _____, Insurance Number _____

Disease : _____,

Name of the Hospital _____,

Date of Admission _____, Date of Discharge _____,

(In case of Out Patient Treatment) period from _____ to _____.

Sl. No.	Procedures	Amount Claimed	As per CGHS guidelines	Less Amt. 15% as not in CGHS	Amount to be sancitoned
1.	Registration Fees				
2.	Admission Charges				
3.	Package Charges				
4.	Out of package				
a)	Bed Charges				
b)	ICU charges				
c)	Investigation charges				
d)	Medicines				
e)	Doctor Charges				
f)	Chemo Plan Charges				
g)	Dressings				
h)	O.T.				
i)	Oxygen charges				
j)	Implant				
k)	Physiotherapy				
l)	Ventilator				
m)	Nebuliser				
n)	Syringe pump				
o)	Alpha / Air Bed				
p)	Blood Transfusion				
q)	Tracheostomy				
r)	Glucostrip (Bed side)				
s)	X-ray				
5.	Any other				