



GURU GOBIND SINGH INDRAPRASTHA UNIVERSITY
Sector-16C, Dwarka, New Delhi-110078

No. GGSIPU/COF/2017/

Dated: 26th May, 2017

OFFICE ORDER


Sub: Revision of Medical Reimbursement Claim - reg.

This has reference to the Office Memorandum No. S. 11011/9/2012-CGHS (P) dated 5th June, 2014 and No. 4-18/2005-C&P [Vol.I - Pt. (I)] dated 20th February, 2009 issued by the Ministry of Health & Family Welfare, Govt. of India to improve the facilities under CGHS and simplify / liberalize the procedures to make the Scheme user friendly.

In supersession to all the Office Orders / Orders and forms issued by the GGS IP University for Medical Reimbursement Claim, the following forms have been prescribed as per the aforementioned Office Memorandum to be used for the reimbursement of any claim by the employees of GGS IP University:


Form MRC (S) is enclosed for all the employees of GGS IP University.

This issues with the approval of Hon'ble Vice Chancellor.


(C. Arvind)
Registrar

Copy to:-

1. All Deans, GGSIPU(USBT/USCT/USBAS/USICT/USEM/USMS/USLLS/USHSS/USE/UCMS).
2. All Directors, GGSIPU
3. All Heads of School / Branch / Deptt., GGSIPU.
4. Controller of Examinations, GGSIPU.
5. Executive Engineer, UWD, GGSIPU / Librarian, GGSIPU
6. In-charge (Personnel / Purchase) / Medical Officer, GGSIPU
7. A.R. to Hon'ble Vice Chancellor / A.R. to Registrar
8. FOs/DDO/AAOs/SO/Staff, Finance & Accounts Department.
9. UITS Department – for uploading the same in the University website under the link of Finance & Accounts Department.


(Shailesh Gupta)
Finance Officer

ANNEXURE-II

**Draft for Affidavit on Stamp Paper for claiming medical reimbursement
IN CASE OF DEATH of a University Employee/Dependent**

I _____ husband/wife/son/daughter of Late _____ and resident of _____ hereby submit the medical reimbursement claim papers pertaining to treatment of my Husband/Wife/Father/Mother Late Shri/Smt _____ who has expired on _____ (copy of Death Certificate is enclosed)

Late Shri/Smt _____ has left behind the following other legal heirs, none of whom have any objection if the entire reimbursable amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp Paper is enclosed

Deponent

Attested by Notary Public

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Draft for No Objection Certificate on Stamp Paper.

We (i) _____ S/o D/o Late Shri _____
(ii) _____ S/o D/o Late Shri _____
(iii) _____ S/o D/o Late Shri _____
(--)
(--)
(--)

Being the legal heirs of Late Shri/Smt _____ have no objection if the entire amount reimbursable pertaining to the treatment of late Shri/Smt _____ is paid to Shri/Smt _____

(i) (Signature)

Name :

Address :

(ii) (Signature)

Name :

Address:

(iii) (Signature)

Name:

Address:

(iv) _____

(v) _____

(vi) _____

Verified by Notary Public



GURU GOBIND SINGH INDRAPRASTHA UNIVERSITY

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled by the Employee in BLOCK LETTERS)

1. (a) Name of the Employee :
(b) Medical Card Number :
(c) Employee Code :
(d) Designation :
(e) Ward Entitlement – (Pvt/Semi.Pvt/General) :
(f) Branch Posted at :
(g) Full Address :

(f) Mobile/Telephone and email address if any :
2. (a) Patient's Name :
(b) Relationship with the Employee :
3. Name & Address of the hospital/diagnostic center/imaging center where treatment is taken or test done :
4. Whether the hospital /diagnostic/imaging center is empanelled under University/DGHS/CGHS :
5. Treatment for which reimbursement is claimed :
(a) OPD Treatment/Test & Investigations :
(b) Indoor Treatment :
6. Whether treatment was taken in emergency :
7. Whether prior permission was taken for the treatment (Yes/No) (If yes copy of approval may be enclosed with the claim form) :
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) OPD Treatment (Summary Sheet may be enclosed separately with the claim form) :
(b) Indoor Treatment (Summary Sheet may be enclosed separately with the claim form) :
(c) Tests/Investigation :
11. (a) Name of the Bank :
(b) SB A/c No. :
(c) Branch MICR Code :
(d) 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 University Medical Scheme beneficiary and the Medical card was valid at the time of treatment. I agree for the reimbursement as is admissible under rules.

Date : _____

Placed :

Signature of the Employee

Documents to be attached

1. Photo copy of University Medical Card.
2. Copy of permission letter if any.
3. Emergency Certificate (original), in case of emergency
4. Copy of the Discharge Summary.
5. Ambulance Certificate (original), if any.
6. Original bills/cash memo/vouchers etc. For the reimbursement amount claimed.

IMPORTANT

Kindly ensure to provide the following documents, wherever applicable:

- (a) Obtain Break up of Investigations from the hospital/dagnostic center/imaging center (details and rates on individual tests and the exact number of tests, x-ray films, etc.) as the reimbursable amount is calculated as per approved rates per test.
- (b) In case of loss of original papers. Affidavits as per Annexure I to be submitted. All photocopies of the bills to be attested by the treating doctor/specialist.
- (c) In case of death of the card holder, Affidavit as per Annexure II to be filled and attached to claim reimbursement.
- (d) In case of implants, Invoice No. Along with sticker with serial number of the implant to be attached.
- (e) In case of Coronary Stents, outer pouch of stents to be enclosed.
- (f) In case of replacement of pacemaker/ICD etc. Copy of the warranty certificate of earlier pacemaker/ICD may be enclosed.

Note : Misuse of CGHs facilities is a criminal offence. Penal action including cancellation of Medical Card may be taken in case of wilful suppression of facts or submission of false claims/statements

Annexure-I

Draft for Affidavit for Duplicate Claim Papers/bills on Stamp Paper

I _____ son/Wife/daughter of _____ and resident of _____ have lost /misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim papers from any source and that if the original papers are traced. I shall not stake claim against original bills in future and that in the event, I receive any cheque against the original bills in future, I shall return the same to competent authority.

Deponent

Verified by Notary Public