SOUTHERN RAILWAY
CHENNAI DIVISION
MEDICAL DEPARTMENT

MEDICAL REIMBURSEMENT CLAIM FORM

Instructions:

- Fill out the reimbursement form completely and accurately to avoid delays in processing.
- All Mandatory documents to be furnished by the Railway Medical Beneficiaries (serving/retired) while submission of the claims for reimbursement of medical expenses.
- Claim to be submitted in Two sets (One Original file & One Xerox File)
- Please note that claims exceeding 5 lakhs must be submitted along with a soft copy of the claim form and supporting documents in the following email

idcms@mas.railnet.gov.in.

Chief Medical Superintendent / MAS.

SOUTHERN RAILWAY - CHENNAI DIVISION

REIMBURSEMENT CLAIM FORM

1 Name of the Railway/Retd.Employee (in BLOCK letters) _____

2 Designation of the Railway/Retd.Employee: (in BLOCK letters) _____

3 Office and Station of employment _____

4 Pay/Last Pay of the Railway/Retd.Employee (Including Grade Pay) _____

5 Residential Address _____

_____

_____

_____

6 UMID/MIC/RELHS No. and Issuing Authority _____

7 UMID/MIC/RELHS registered at HU/Hospital _____

I (A) Name and age of the Patient _____

II (B) Patient's relationship to the Railway/Retired Employee _____

III Details of Indoor/OPD Treatment at Non Railway Institute

A. Name of Hospital: _____

B. Date of Admission: _____

C. Date of Discharge: _____

D. Diagnosis: _____

E. Amount of Total Hospital Bill: (Attach detailed bill) _____

F. Whether Treatment was taken in Emergency: _____

G. Are you a CTSE member (Yes/No): _____

IV Whether subscribing to any Health Insurance Policy or covered under any other health scheme (Yes/No): _____.
If yes, have you received any amount from Insurance Company for the treatment in question. Give details if any on separate sheet of paper.

V Total Amount Claimed : _____

VI Details of Bank account where Reimbursement amount is to be paid:

Name of Bank: _____ Account No.:_____

Branch MICR Code:_____IFSC Code:_____

VII List to enclosures (Please Tick the documents attached and write additional documents)

A Photocopy of MIC/RELHS Card

B Essentiality cum Emergency Certificate by the Non Railway Hospital

C Discharge Summary

D Original Bills of Hospitals

E Original Cash Vouchers of Drugs/Consumables/Implants etc. if relevant

F Outer pouch of Stent, Pacemaker, Implants etc.

G Any other enclosures _____

(In case of many enclosures, write number of additional enclosures here and attach a separate sheet with details)

DECLARATION TO BE SIGNED BY THE RAILWAY EMPLOYEE

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me. I am aware that misuse of medical facilities or misrepresentation of any kind can attract penal action including cancellation of MIC/RELHS Card. I hereby declare that this is my final claim and I shall not make any claim in future to Railway or any other health scheme in respect to this treatment episode.

Date :

Place : **Signature of the Railway Employee**

In case the beneficiary has medical insurance policy and intend to make claim for the treatment in question then he/she may make claim to insurance company first and then submit claim to Railway with documents, bills, etc, attested by insurance company.

SOUTHERN RAILWAY

MEDICAL DEPARTMENT

ESSENTIALITY cum EMERGENCY CERTIFICATE

I certify that Shri/Shrimati/Kumar/Kumari _____ wife/son/daughter/dependent relative of Shri/Shrimati _____ employed in Indian Railway as _____, has been under my treatment for _____ disease from _____ to _____ at the M/s_____ _____ hospital and the treatment as described in the attached Discharge Card No._____ and attached bills thereon were provided due to an emergency situation, treatment for which could not have been delayed. I further certify that the treatment provided was essentially required.

.....

Signature of the Medical Officer
In charge of the case at the Non-Railway Hospital
with Name and Stamp/Seal

.....

Signature of the Hospital In-Charge or
Authorized Signatory with Stamp/Seal

CHECKLIST FOR MEDICAL REIMBURSEMENT CASES.

(a) Ref. Board's letter Nos.:
- (i) 2005/H/6-4/Policy/IIdt.31.01.2007
- (ii) 2007/H/6-4/Policy–Idt.26.11.2007
- (iii) 2007/H/6-4/Policy-1dt.07.8.2008

(b) Manual References (Medical/Personnel/Accounts Depts.):-
- (i) Indian Railway Medical Manual 2000 Para 648 to 666

S. No.	Documents	Original or Photocopy required	Yes/ No/ Not Applied
1.	Forwarding letter from concerned department Head/Officer/Supervisor	Original	
2.	Application from Employee/Claimant	Original	
3.	Whether patient is dependent upon the Railway employee. If yes, the necessary declaration by the employee that patient is wholly dependent Upon him and resides with him, should been closed and Cross checked.	Photocopy	
3.A	Whether case referral by AMA or otherwise (referred or non-referred)/ MO/200	Original	
4.	If referred by Railway Doctor, certificate to the effect should be Enclosed/referral letter.	Original	
4.A	Whether employee has claimed the reimbursement within the Stipulated period of six months from the date of completion of treatment	YES/NO	
4.B	Whether delay has been condoned by the Controlling Officer, in case if Delay in submitting the claim is **more than 6 months**	Original	
7.	All original hospital bills duly verified and signed by treating Private Doctor with register number and seal	Original	
8.	All original medicine bills duly verified and signed by treating Private Doctor with register number and seal	Original	
9.	All original investigation bills duly verified and signed by treating Doctor with register number and seal	Original	
10.	Railway Board Annexure-IV (Form available at CMS's Office)	Original	
11.	Emergency-cum-essentiality certificate issued by treating Private Doctor With sign and seal with register number	Original	
12.	Discharge summary/Transfer summary/Death summary in original	Original	
13.	Attested Photocopy of UMID	Photocopy	
14.	Photocopy of Passbook/Cancelled Cheque(2copies)	Photocopy	
15.	Death certificate in case of death of the railway beneficiary. Legal Heir Certificate with attestation and No objection certificate	Attested photocopy	
16.	Declaration for "no insurance" claim for this treatment by the applicant	Original	

Check List signed by: (a) Health Unit: _____

(Name, Designation & Date)

(b) RH/PER

_____

(Name, Designation & Date