

REIMBURSEMENT CLAIM FORM

(ANNEXURE (A) TO LETTER NO. 494- E/Q VII DT. 24.2.99 amended vide
Railway Board's letter No.2005/H/6-4/ Policy-I, Dated 01.06.2017)

1. Name of the Railway/ Retired Employee (in BLOCK letters):
2. Designation of the Railway/ Retired Employee (in BLOCK letters):
3. Office and Station of Employment:
4. Pay/Last Pay of the Railway/ Retired Employee including grade pay:
5. Residential address:
.....Phone No.
6. Medical I. Card /RELHS No. : and Issuing Authority:
7. Medical I. Card /RELHS registered at Health Unit/ Hospital. :
- II. (A) Name and age of the Patient : Age : Years
- II. (B) Patient's relationship to the Rly./Retd. Employee:
- III. Details of Indoor 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 CSTE Member (Y/N):
- IV. Whether subscribing to any Health Insurance Policy or covered under any other Health Scheme. 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.
 - a. Name of Bank: b. Account No. :
 - c. Branch MICR Code: d. IFSC Code:

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

- A. Photocopy of Medical I/Card/RELHS Card.
- B. Essentiality-cum- Emergency Certificate by the Non Rly. Hospital.
- C. Discharge Summary.
- D. Original Bills of Hospital.
- E. Original Cash Vouchers of Drugs/Consumables. Implants etc. if relevant.
- F. Outer Pouch of Stent, Pacemaker, Implants etc.
- G. Any other enclosure _____

(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 for 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 Health scheme in respect to this treatment episode.

.....
Signature of Railway employee/ Claimant

Date

Place

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.

**Essentiality Cum Emergency certificate
NORTHERN RAILWAY
MEDICAL DEPARTMENT**

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 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.

Date :

.....
Signature of the Medical Officer
In charge of the case at the non-Railway Hospital.
With Name and Stamp/Seal.

Date :

.....
Signature of Hospital In-charge or
Authorized signatory with Stamp/Seal.

ECS/RTGS MANDATE FORM

01	NAME of claimant & Relation	
02	Designation & Under whom working	
03	Name of the Bank	
04	Address of the Bank	
05	CITY	
06	Account Number	
07	Type of Account	SAVING / CURRENT
08	MICR Code	
09	RTGS/ IFS Code of the Branch of Bank	
10	PAN Number	

1. I hereby declare that the particulars given above are correct and complete.
2. Copy of Crossed Cheque is enclosed herewith.

Signature of Claimant/Applicant

Name:- _____

Residential address: - _____

Contact Number:- # _____