

**NATIONAL INFORMATICS CENTRE**  
 Department of Information Technology  
 Ministry of communications and Information Technology  
 Government of India

**CHECKLIST FOR MEDICAL REIMBURSEMENT**

[The checklist must be attached with the form of application. Without the checklist, the claim form will be summarily rejected]

		Please Tick the Appropriate Box		
		For Claimant		For Office
		Yes	No	Verified
1.	Patient is wholly dependent on claimant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Medial-97 form compulsorily filled up (wherever applicable) Attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Photo copy of the C.G.H.S token card (both side) attached (If Applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Original/Duplicate vouchers verified/duly signed with rubber stamp by treating physician attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Essentiality Certificate A/B (as applicable) duly filled and countersigned by Medical Officer/ Medical Super indent with rubber stamp and attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	a. Copy of Discharge Certificate / Summary attached ( in case of indoor treatment only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Copy of Prescriptions (in case of out door treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Breakup of Laboratory/Investigation charges and doctor's visit charges indicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Certificate of Special Nursing attached (if special nursing is availed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Blood Non Availability certificate from the Hospital Blood Bank attached (in case of blood purchased from out side)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Copy of the CGHS/Office Permission Letter attached (if obtained)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Detailed list of all the medicines in capital letters attached (voucher wise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Self Explanatory Letter attached ( in case, the treatment has been taken from private. Un recognized Hospital) for justifying the claim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Emergency Certificate from the Hospital ( if treatment taken in emergency without following procedure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Claim submitted within 90 days of completion of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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15. In case, the treatment is taken in a Private un – recognized Hospital, the distance in kms. From the place of illness to
- a. Private Hospital
  - b. Nearest Govt. Hospital
  - c. Nearest Private Recognized Hospital

Signature of the Claimant (with Date)

Name  
Employee Code  
Designation  
Place of Posting  
Telephone/I.Com No.,  
Email Address

Date:

**For Office Use Only**

Above information has been checked and verified as provided in the box mentioned against each.

- i) Information in r/o Sl. No.....above is/are not proper. The claim is, Therefore, returned herewith for want of requisite information. \*  
or
- ii) Claim has been scrutinized as per approved rates and found eligible for reimbursement of Rs.....(Rupees.....)  
Director (Admn.) being the competent authority may kindly see for approval of reimbursement of Rs.....  
To Sh./Ms.....(Name)  
.....(Designation) for his  
..... (relation with the patient) treatment.\*

Note: You can make additional comments, if required. \* Strike out, whichever is not applicable

**Initials of the Dealing Assistant**

**Signature of In charge (Admn.)  
with stamp**

Verified the claim for Rs.....(Rupees.....)

**Initials of the Dealing Assistant**

**Signature of D.D.O with stamp**

Recommendation / Comments of Officer-in-charge/SIO.

**Signature of Officer-in-charge/ SIO  
With Stamp**

Director (Administration)