

Form –C4**Reimbursement for cost of Non-Cashless In-Patient Department (IPD) treatment in Empanelled/Enlisted Hospital****under West Bengal Health Scheme**

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office)

Part-I[General Information]

1. Details of Employee/Pensioner			
Full Name <i>(in Block letters)</i>		HRMS ID / PPO No.	
Enrollment ID No.		Claim Application ID. <i>(To be filled at the time of online entry from the end of Head of Office)</i>	
2. Details of Patient, Treating Hospital and Condonation Requirement, if any			
2.1	Name of Patient		
2.2	Name of Empanelled/Enlisted hospital where treatment was availed		
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes <input type="checkbox"/>	No <input type="checkbox"/> Not known <input type="checkbox"/>
3. Details of Claimant <i>(applicable in case of death of employee or pensioner or family pensioner)</i>			
Sl. No.	Name of claimant	Relation	
3.1			
4. Permission Details (If any)			
Sl. No.	Permission sought	Details of permission approval	
4.1	For treatment availed in empanelled private hospital within West Bengal[see clause 14 of Order No. 796 and 797, dated 31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]	Permission ID : Permission approved for:	
4.2	For treatment availed in enlisted hospital outside West Bengal (see clause 14 of Order No.7287, dated 19.09.2008).	Memo No. : Date: Designation / Authority : U.O. No. and date of Finance Deptt. West Bengal, if any:	

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Reimbursement Mode (If No is selected in Sl. No 3)					
Period of treatment		Admission Date		Discharge date	
6. Type of Discharge					
Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal	<input type="checkbox"/>	6.3	Referral	<input type="checkbox"/>
6.2	Risk Bond	<input type="checkbox"/>	6.4	Death	<input type="checkbox"/>
7.Amount Claimed for					
Sl. No.	Type of Treatment				(Tick mark in appropriate box)
6.1	Only Procedural/ Package Treatment				<input type="checkbox"/>

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6.2	Only Non- Procedural/ Non-Package Treatment				<input type="checkbox"/>
6.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment				<input type="checkbox"/>
7.1 Details of Procedural/ Package Treatment					
Period of Procedural/ Package Treatment			From		To
Sl.No.	Name of Procedures/ Packages		Procedure Code	Amount Claimed(Rs.)	
7.1.1					
7.1.2					
7.1.3					
7.1.4					
7.1.5					
Total					
7.2 Details of Implants Used					
Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)	
7.2.1					
7.2.2					
7.2.3					
7.2.4					
7.2.5					
Total (Rs.)					
7.3 Details of Non-Procedural/ Non-Package Treatment.					
Period of Non-Procedural/ Non-Package Treatment.			From		To
Sl. No.	Name of Component				Amount Claimed (Rs.)
7.3.1	Room/ Bed Rent				
	ICCU/ITU/ICU/NICU/PICU	From		To	
	HDU/SDU	From		To	
	Burn Unit	From		To	
	CRIB	From		To	
	General/Semi-Private/Private	From		To	
7.3.2	Consultation Fees.				
7.3.3	Pathological and Radiological Investigations.				
7.3.4	Medicines.				
7.3.5	Consumables				
7.3.6	Special Nursing/Aya Charges				
7.3.7	Miscellaneous. (If any specify)				
Total Claim of Reimbursement Mode of Treatment(Rs.) (amount mentioned in 7.1+ 7.2+7.3)					
No. of vouchers					

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

8. Indoor related OPD treatment

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Do you want to claim Indoor related OPD treatment cost i.e cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)		Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Details of Indoor related OPD Consultation			
Dates		Nos. of Consultation	
10. Details of Indoor related OPD treatment Expenditure			
Sl. No.	Name of Components		Amount Claimed (Rs.)
10.1	Consultation Fees		
10.2	Cost of Pathological and Radiological Investigations		
10.3	Cost of Medicines		
	Period of medicine consumption	From	To
10.4	Cost of Special Device		
10.5	Miscellaneous (specify)		
Total claim of indoor related OPD(Rs.)			
Nos. of vouchers			

Part-IV [Medical Advance]

12. Details of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Voucher No.	Treasury Voucher Date	Amount (Rs.)

Part-V [Refund of Medical Advance]

13. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (Rs.)

Net Claim: [Part-II plus Part-III minus Part IV] or [Part-II plus Part-III minus Part IV plus V]	
Rs. ;	In words; Rupees

Part-VI [Declaration of Employee/Pensioner]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses are incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrollment certificate at the time treatment. I will be personally responsible and liable for any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim finds false and malafide due to any suppression of facts. I am enclosing the following instruments to substantiate my claim in sequential manner.

[List of Enclosures]

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Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
1	Enrollment Certificate of beneficiary	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Bill Summary of Indoor Treatment and OPD treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Money Receipts of both Indoor and OPD treatment in sequence manner (In chronological order)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	Copy of related OPD Prescriptions (if claimed)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Copy of Discharge Summary (Case summary in case of death) and OT note copy of death certificate	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Copy of permission granted if any	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7	Copy of compliance of clause (3) or (4) or (5) as per Memo No. 11253(80) F (MED), dated 16/12/2011	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	Copy of Detailed Bill of Indoor Treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9	Original copy of Voucher/ Tax Invoice/Challan of Implants	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10	Copy of all investigations/ tests report of Indoor and Indoor related OPD treatment sequentially	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11	In case of death of Employee, Pensioner and Family Pensioner; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/>
12	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13	Any other instruments (Specify)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Date:

Signature of the Employee/Pensioner/Claimant :
Name in Block Letters :
Designation/Last Designation :