V.O. CHIDAMBARANAR PORT TRUST
FINANCE DEPARTMENT
ESTABLISHMENT SECTION

No:FIN-OFFAO-MIS-CHECK-V1-14 **Dated:03.10.2016**

Sub:- The claim forms for Medical Reimbursement bills in r/o working and retired employees – Revised – Reg.

Kind attention is invited to this office letter No._FIN-OFFAO-MIS-CHECK-V1-14/D.2241, Dated:15.09.2016 on the above mentioned subject.

2. The Check lists for working and retired employees forwarded in the above reference have been slightly modified and the same are sent herewith to follow in forthcoming claims.

Encl: as above

FINANCIAL ADVISER &
CHIEF ACCOUNTS OFFICER

To
The Chief Medical Officer (Stat) / VOCPT

Copy to

1. PA to Dy.CPT
2. The Deputy Chief Medical Officer/VOCPT
3. Guard File

V.O. CHIDAMBARANAR PORT TRUST
CLAIM FORM FOR MEDICAL REIMBURSEMENT BILLS
IN RESPECT OF WORKING EMPLOYEES

Sl.No.	Details	Remarks
1	Name of the Employee	
2	Designation	
3	Employee No.	
4	Medical ID No.	
5	Name of the Patient	
6	Relationship with Employee	
	a) Self or Spouse	
	b) Dependent	
7	**In case of dependent of the Employee**	
	(i)Whether name has been enrolled in the Medical Identity Card	
	(ii) Date of Birth and Age of the Dependent (Copy of Medical ID card failing which details available in medisoft system to be enclosed)	
	(iii) Below 25 years/Above 25 years	
	(iv) Whether the monthly income is limited as per the CS (MA) rules i.e. Rs.3900/-+ amount of the Dearness relief on the basic Pension of Rs.3900/- as per pay revision orders for Port.	
8	Name & place of the Hospital	
9	Period of Treatment	
10	Referral Hospital (or) Non referral Hospital	
11	In case the treatment was at referral Hospital, whether the treatment was recommended by the Medical Department	
12	In case the treatment was at Non referral Hospital, whether intimation was given by the Employee about the present treatment taken	YES / NO If Yes, date of intimation & Copy of the Intimation to be enclosed
13	Whether the Hospitalisation was due to Emergency situation or Normal	

14	Total Bill Amount claimed	Rs. Rupees in words
15	**Enclosures** 1.No of Original Bills 2.Medical reports 3.Certificates(A&B) 4.Copy of Medical ID card or details in medisoft system 5.Copy of the reference letter	
I also declare that the information furnished above is true to the best of my Knowledge and belief. Date: SIGNATURE OF THE EMPLOYEE		
	For the use of Medical Department	
16	Medical Department's recommendation-whether the case is recommended for Reimbursement or Not	Yes / NO If Yes, admissibility of bill to be regulated under CGHS Rates/ CSMA Rates
17	Admissible amount as per CGHS rates 2014/ CSMA Rates	Rs. Rupees in words
18	Prescribed format to show the admissiblity is enclosed	YES / NO
19	**For referral cases the Competent Authority** as per Sl.No 50 of Annexure(Non-Statutory) of DOP Issued by Ministry vide letter No.17011/1/2005 PG, Dated:11.02.2015	Dy.CPT
20	**For Non referral cases, the Competent Authority as per Sl.No.2(b) of revised DOP issued by Finance Department vide letter No.A-2/3/2013-Regns/D.1429 Dt.30.04.2014** CMO - Rs. 5000/- per claim Dy.CPT - Rs.25,000/- per claim CPT - Full Powers	

Note: Certified that Sl.NO.13 has been examined and confirmed by Medical Department.

Dy.CMO **A.O. Gr.II**

V.O. CHIDAMBARANAR PORT TRUST

CLAIM FORM FOR MEDICAL REIMBURSEMENT BILLS

IN RESPECT OF RETIRED EMPLOYEES

Sl.No.	Details	Remarks
1	Name of the Pensioner	
2	Designation & Date of Retirement	
3	Pensioner No.	
4	Medical ID No.	
5	Name of the Patient	
6	Relationship with Pensioner	
	a) Self or Spouse	
7	Medical Allowance if any drawing from the Port	Yes/ No
8	Name & place of the Hospital	
9	Period of Treatment	
10	Referral Hospital (or) Non referral Hospital	
11	In case the treatment was at referral Hospital, whether the treatment was recommended by the Medical Department	
12	In case the treatment was at Non referral Hospital, whether intimation was given by the pensioner about the present treatment taken	YES / NO If Yes, date of intimation & Copy of the Intimation to be enclosed
13	Whether the Hospitalisation was due to Emergency situation or Normal	
14	Total Bill Amount claimed	Rs.
		Rupees in words

15	**Enclosures** 1.No of Original Bills 2.Medical reports 3.Certificates(A&B) 4.Copy of Medical ID card or details in medisoft system 5.Copy of the reference letter	
I also declare that the information furnished above is true to the best of my Knowledge and belief. Date: SIGNATURE OF THE PENSIONER		
	For the use of Medical Department	
16	Medical Department's recommendation-whether the case is recommended for Reimbursement or Not	Yes / NO If Yes, admissibility of bill to be regulated under CGHS Rates/ CSMA Rates
17	Admissible amount as per CGHS rates 2014/ CSMA Rates	Rs. Rupees in words
18	Prescribed format to show the admissiblity is enclosed	YES / NO
19	**For referral cases the Competent Authority** as per Sl.No 50 of Annexure(Non-Statutory) of DOP Issued by Ministry vide letter No.17011/1/2005 PG, Dated:11.02.2015	Dy.CPT
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Dy.CMO **A.O.Gr-II**