

REIMBURSEMENT CLAIM FORM

- 1) Name of the Railway/Retd. employee (in BLOCK Letters) _____
- 2) Designation of Railway/Retd. employee (in BLOCK Letters) _____
- 3) Office & Station of employment _____
- 4) Pay/Last Pay of the Railway/Retd. Employee including grade pay _____
- 5) Residential address _____
- 6) MIC/RELHS no. & issuing Authority _____
- 7) MIC/RELHS register at H. Unit/Hospital _____

- II A Name & Age of the patient _____
B Patient's relationship to 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 (Attached detailed bill): _____
 - F Weather Treatment was taken in Emergency: _____
 - G Are you a CTSE 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 is to be paid:
 - a) Name of Bank _____ b) Account No. _____
 - c) Branch MIRC Code _____ d) IFSC Code. _____
- VII List of enclosures (Please Tick the documents attached and write additional documents)
 - A Photocopy of MIC/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 _____
 - 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 declared 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 intent 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.

_____ RAILWAY

MEDICAL DEPARTMENT

ESSENTIALITY-CUM-EMERGENCY CERTIFICATE

I certify the Shri/Shrimati/Kumar /Kumari _____ wife/son/
daughter/ dependent relative of Shri/Shrimati _____, has been
under my treatment for _____ disease
from _____ to _____ at the _____ hospital
and that 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 Hospital In-charge
or Authorized signatory with Stamp/Seal

MANDATE FORM

BY

CONTRACTOR / VENDOR / Retired Railway Employee/ Beneficiary
for EFT / ECS / RTGS / NEFT / PAYMENT

Name of The Firm / Person / Party :			
Address :			
Telephone No.:		FAX No. :	
Cell Phone No. :		E-mail :	
PAN No. :			
Particulars Of Bank Account:	Bank Name :		
	Branch Name & Address :		
	Bank Branch Telephone No. :		
	Account Type (Whether SB or Current) :		
	Account No. :		
	Bank's MICR Code :		
	Bank's IFS Code :		
Declaration by the Party:	I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not affected at all for reasons of incomplete and incorrect information, the User Institution i.e., S.E.RAILWAY will not be held responsible. I have understood the scheme and agree to discharge the responsibility for which I am liable as a participant under the scheme.		

Date :

Signature of the Party / Retired Employee

NB: One cancelled cheque / photocopy of the Cheque is to be enclosed (where the cheque does not carry I F S Code, an attestation from bank attesting the I F S Code should be given)

Signature Of Bank Official
(Where required)

DOCUMENTS TO BE SUBMITTED

1	REIMBRSEMENT FORM: (to be downloaded from S. E. Railway website (https://ser.indianrailways.gov.in/ → Department- Medical → Documents & Forms) or be collected from Welfare Section of PCPO's office)	duly signed by Doctor
2	MD's Sanction Copy	
3	Original Bill	duly signed by Doctor
4	Cancelled Cheque Or First Page Of Bank Pass Book	
5	Medical Card Or RELHS Card	
6	PAY SLIP	For Working Employee
7	MANDATE FORM	For Retired Employee