FORM A

Application for enrolment under the West Bengal Health Scheme, 2008.

(See sub-clause (1) of clause (4)

TO:
The _____ (Cadre Controlling Authority/ Head of Office)

Sir,
I Shri/ Smt _____ (Designation) _____
attached to _____ (office) under _____
(Department) do hereby opt for coming under the West Bengal Health Scheme, 2008 with effect from 1st day of _____, _____.
(Month) (Year)

The particulars of the members of my family as defined in para 3(e) of the Scheme as amended under notification no. 6722-F dt. 09.07.09 are as follows:

Name of Government Employee :
Designation :
Residential Address :

Date of birth :
Date of entry into Government Service :
Date of superannuation :
Present pay (Band pay + Grade pay) :
G.P.F. A/C No. :

Details of Family

Sl. NO:	Name	Date of Birth/ Age	Relationship	Monthly income, if any
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

I do hereby declare that upon enrolment under the above scheme I shall forgo the regular monthly medical allowance drawn by me as a part of salary.

I further declare that I shall abide by the provisions of the West Bengal Health Scheme, 2008, as may be in force from time to time.

_____
Signature of the Applicant

FORM B

Certificate for enrolment under the West Bengal Health Scheme, 2008

(See sub-clause (3) of clause 4)

Certified that Shri/Smt. _____ (designation) _____ _____ _____ attached to _____ ____Department has been enrolled under the West Bengal Health Scheme, 2008, with effect from 1st day of _____, _____.

(Month) (Year)

The particulars of the Govt. employee and dependent members of family as defined in para 3(e) of the Scheme and amended under notification no. 6722-F dt. 09.07.09 are as follows:

Name of Government employee :
Designation :

Residential address :

Date of birth :
Date of entry into Government service :
Date of superannuation :
Present pay (Band Pay + Grade Pay) :
G.P.F. Account No. :

Details of Family

Sl. No.	Name	Date of birth/Age	Relationship	Monthly income, if any
1.				
2.				
3.				
4.				
5.				

Signature of the Cadre Controlling Authority/
Head of the Office

West Bengal Health Scheme, 2008

Memo. No. _____ Dt. _____

Copy forwarded for information and necessary action to:

1. Shri/ Smt _____ (designation)
2. The _____ (Drawing and Disbursing Officer).

He is requested to discontinue the drawal of regular monthly medical allowance in respect of Shri/ Smt. _____with effect from 1st day of _____ (Month), _____, (Year).

3. Accountant General (A&E), Treasury Buildings, Kolkata.
4. Medical Cell, Finance (Audit) Department, Writers' Buildings, Kolkata- 1.

Signature of the Cadre Controlling Authority/
Head of the Office

West Bengal Health Scheme, 2008

FORM C

Application Form for settlement of claim for reimbursement

under the West Bengal Health Scheme, 2008

(See sub-clause (1) of clause 12)

(To be filled in by the applicant)

1. Identification No. of the Govt. employee :

2. Full name of the Govt. employee with designation (in Block letters) :

3. Full Address:
   (i) Office :

   (ii)Residence :

4. Enrolled under the Health Scheme w.e.f. :

5. Date of superannuation :

6. Pay (Band Pay + Grade Pay) :

7. Accommodation Category [put (√) mark)] : Private/ Semi-Private/ General Ward

8. Medical treatment done : Self or beneficiary

9. Name of the beneficiary & relationship with the Government employee :

10. Name of the Hospital with address and code no.
    (a) OPD treatment :

    (b) Indoor treatment/ Day Care :

11. Period of OPD treatment :

12. Period of indoor treatment :

13. Disease :

14. Total amount claimed-
    (a) OPD treatment :
    (b) Indoor treatment :
    Total :

15. Details of permission
    (a) For treatment in speciality hospital outside the State :
    (b) For human organ transplantation/ ICD/ CRT/ Dual Chamber Pacemaker/ more than two stents/ more than one drug eluting stents, digital hearing aid, etc. as per Memo No. 797-F (MED), dt. 31-01-11. :

16. Details of Medical advance, if any
    (a) Amount :

    (b) Order no. and date :

    (c) Sanctioning Authority :

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am a beneficiary of the West Bengal Health Scheme, 2008, and the enrolment under the Scheme was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Signature of the Govt. Employee

Date:

West Bengal Health Scheme, 2008

FORM "D_1"

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist for OPD Treatment

[*See* sub-clause 12 (3) & clause 7(1)]

1. Name of the Govt. employee with identification No. :

2. Name of Office of the Govt. employee with address :

3. Name of the patient, relationship with Govt. Employee & identification No. :

4. Details of expenditure:

(I) Name of the diagnosed disease :
(* vide list enclosed)

(II) Name & Code No. of the empanelled/ Govt. recognized Hospital :

(III) Period of OPD treatment :

(IV) Total No. of original vouchers & money receipts :

(V) Amount claimed for OPD treatment :

Sl. No.	Description of items	Amount Claimed	Amount admissible (for official use)
(a)	Consultation fees (indicate total no. of consultations)		
(b)	Pathological investigations (give Break-up in a separate annexure with code no.)		
(c)	Radiological investigations (attach separate list, if required, with code no.)		
(d)	Medicines (give details of purchase in separate annexure, if required)		
(e)	Special devices like hearing aid/artificial appliances etc. (specify)		

(f) Miscellaneous (specify)

Total

(Rupees: *only)*

(Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the relevant bills/vouchers have been verified by me in pursuance of the latest approved rates of the WBHS, 2008 and the expenditures shown above are correct and the treatment services prescribed and provided were essential and minimum that required for the recovery of the patient.

2. Certified that the patient, Sri/Smt._____ was/ has been suffering from_____as listed in Sl. No._____ of the WBHS OPD list below*.

Counter signed by

(Signature of the Treating Specialist with official seal)

Administrative officer/Medical Superintendent of
the empanelled/ recognized Hospital with official seal

***OPD Disease List as per clause –7 of the WBHS, 2008**

(i) Malignant diseases,

(ii) Tuberculosis,

(iii) Hepatitis B/C and other liver diseases,

(iv) Insulin-dependent diabetes,

(v) Heart diseases,

(vi) Neurological disorders/Cerebrovascular disorders,

(vii) Malignant malaria,

(viii) Renal failure,

(ix) Thallasaemia/Bleeding disorders/Platelet disorders,

(x) Injuries caused by accidents.

(xi) None of the above list (Specify name of the ailment)
[vide Para-10 of Memo No. 797-F (MED), dated 31-01-2011]

West Bengal Health Scheme, 2008

FORM "D_2"

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist

for Indoor/Day Care Treatment and related OPD treatment

[See Clause 12(3), clause 6, clause 7(2) & clause 9]

1. Name of the Govt. employee with identification No. :

2. Name of Office of the Govt. employee with address :

3. Name of the patient, relationship with Govt. Employee & identification No. :

4. Details of expenditure:

(I) Name of the diagnosed disease :

(II) Name & Code No. of the empanelled/ Government recognized Hospital :

(III)Period of Indoor/Day Care treatment :

(IV)Total No. of original vouchers & money receipts :

(V) **Details of Amount claimed**

(A) for Package treatment from _____ to _____ :

Sl No.	Procedure Name	Procedure Code No.	Amount Claimed (Rupees)	Amount admissible (Rupees) (for official use)
(1)	(2)	(3)	(4)	(5)
(i)				
(ii)				
(iii)				
(iv)				
(v)	**Miscellaneous** (Specify & give details in separate sheet, if necessary)			
		Total=Rupees		

(B) **for Non-Package treatment from _____ to _____**

Sl No. (1)	Description of items (2)	Item Code (3)	Amount Claimed (Rupees) (4)	Amount admissible (Rupees) (for official use) (5)
(i)	Room Rent : (a) Ward			
	(b) ICU/ ITU/ CCU/ NICU/ PICU			
	(c) HDU/Step Down Unit/Burn Unit			
(ii)	Charges for : (give details with code nos. in separate annexure)			
	(a) Indoor visit of specialist/ super specialist			
	(b) Radiological Investigations			
	(c) Pathological Investigations			
	(d) Medicines			
	(e) Artificial devices			
	(f) Miscellaneous (specify)			
	Total :	**=Rupees**		

(VI) **Related OPD treatment in terms of Clause-9 or Clause-7(2)**

Sl No. (1)	Description of items (2)	Amount Claimed (Rupees) (3)	Amount admissible (Rupees) (for official use) (4)
(i)	Consultation fees (indicate total no. of consultations)		
(ii)	Charges for : (give details with code nos. in separate annexure)		
(a)	Pathological investigations		
(b)	Radiological investigations		
(c)	Medicines		

(1)	(2)	(3)	(4)
(d)	Special devices like hearing aid/artificial appliances etc. (specify)		
(e)	Miscellaneous (specify)		

Total: **= Rupees** _____ _____

Grand Total (package + non-package+ OPD amount) ***=Rupees***

(Rupees: *only)*
(in words)

(Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the relevant bills/vouchers have been verified by me as per latest approved rates of the WBHS, 2008 and the expenditures shown above are correct and the treatment services provided were essential and minimum that required for the recovery of the patient.

2. Certified that the services of Special Nurse/Ayah were required from _____ to _____ that were absolutely essential for the recovery of the patient.

3. Specific procedure/Operation performed was _____ on _____.

4. Conservative treatment provided from _____ to _____.

(Signature of the Treating Specialist with official seal)

Countersigned by Medical Superintendent/
Administrative officer of the empanelled/
recognized Hospital with seal

West Bengal Health Scheme, 2008

FORM "D3"

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist for treatment services taken from non-recognised Private Hospital/ Nursing Home

[*See* Para-23 of the FD memo no. 797-F (MED), dt. 31.01.2011]

1. Name of the Govt. employee with identification No. :

4. Name of Office of the Govt. employee with address :

5. Name of the patient, relationship with Govt. Employee & identification No. :

4. Details of expenditure:

(I) Name of disease (* vide list enclosed) :

(II) Name & Address of the Hospital :

(III) Period of treatment :

(IV) Total No. of original vouchers :

Details of Amount claimed:
(give details in separate annexure, if required)

Sl. No.	Description of items (* vide list enclosed)	Treatment Period	Amount claimed (Rupees)	Amount Admissible (60% of approved Package rate) (Rupees) (for official use)
(1)	(2)	(3)	(4)	(5)
(i)				
(ii)				
(iii)				

(iv)

Total= Rupees _____ _____

(Rupees: *only)*
(in words)

(Signature of Claimant)

Name in Block Letters

Address:

1. Certified that the patient had been admitted under my care at _____Hospital/Nursing Home as an emergency case. The Specific procedure/Operation performed was _____ on _____.
2. Certified that the relevant bills/vouchers have been verified by me and the expenditure shown is correct and the treatment services provided were essential and minimum that was required for the recovery/stabilization of the patient.
3. Certified that the treatment was done in an organization that has a License under the West Bengal Clinical Establishment Act and Rules and the licence no is _____ and is valid up to _____.

Countersigned by Medical Superintendent/
Administrative officer of the Private Hospital/
Nursing Home with seal

(Signature of the Treating Specialist with official seal)

*List as per Para 23 of Memo No. 797-F (MED), dt. 31-01-2011

(a) Accidental injury,

(b) Acute Appendicitis operation on emergency basis,

(c) Delivery on emergency basis,

(d) Haemodialysis,

(e) Removal of foreign body on emergency basis.

West Bengal Health Scheme, 2008

FORM E

Checklist for Reimbursement of Medical Claims/ Sanction of Advance

(*See* sub-clause (3) of clause 12)

1. Employee's Identification No. & date of enrolment :

2. Full name & designation
   (block letters) :

3. (a) Name of office with address :

   (b) Directorate :

   (c) Department :

4. Whether claim is for employee himself or his beneficiary, if for his beneficiary, mention – :

   a) Name of the beneficiary and relationship with employee :
   b) Beneficiary's Identification No. :
   c) Validity of the Card up to :

5. Entitlement of accommodation (Put tick mark) : Private/Semi-Private/General ward

6. Disease :

7. Name of the hospital where treatment was done/to be done /is going on :

8. Whether treatment was done in non-empanelled hospital : Yes/No
   If yes –
   a) Name of the hospital/nursing home with Clinical Establishment licence No. and address :

9. Period of treatment: a) OPD : from _____ to_____

   b) Indoor/ Day Care treatment : from _____ to_____

10. Details of advance sanctioned -
    a) Amount :
    b) Order No. & date :
    c) Sanctioning Authority :

11. a)Treatment done within the State-

    (i) Copy of intimation letter furnished : Yes/No.
    (Vide Clause-11 of the West Bengal Health Scheme, 2008)
    (ii)Copy of permission letter furnished : Yes/No.
    (For human organ implantation/ Dual-chamber pacemaker/ AICD/ CRT/ more than one drug eluting stents Implantation, etc.) (Vide Clause-8 & 9 of Finance Deptt. Notification No. 796-F (MED), dated 31-01-2011)

    b) Treatment done outside the State –
    Copy of permission letter furnished : Yes/No.

12. (A) Whether the claim for reimbursement has been preferred within

(i) three months from the date of discharge of indoor treatment :
(ii) three months from the date of consultation of OPD treatment :
(iii) three months from the date of purchase of medicines, etc. (for continuous OPD treatment) :

(B) If not, whether delay in preferring claim has been condoned by the West Bengal Health Scheme Authority under the Finance Department :

13. The following documents are submitted (please tick [√] the relevant column) :

(a) Photocopy of the Health Scheme Identity Card of
I) Govt. employee : Yes/No.
II) Beneficiary : Yes/No

(b) Essentiality Certificate (as specified) : Yes/No.

(c) Copy of discharge summary : Yes/No.

(d) Copy of OPD prescription : Yes/No

(e) Total Number of original bills & cash memos :

(f) Detailed list/Statement of medicines furnished : Yes/No

(g) Detailed list of investigations furnished : Yes/No

(h) Original papers have been lost the following documents are submitted-

(I) Photocopies of claim papers : Yes/No.

(II) Affidavit on stamp paper : Yes/No.

(III)Photo copy of Police Diary : Yes/No.

(i) In case of death of Govt. employee following documents are submitted-

(I) Affidavit on stamp paper by claimant : Yes/No.

(II) No objection from other legal heirs on stamp papers : Yes/No.

(III) Copy of death certificate : Yes/No.

Dated.....

Signature of the Applicant

West Bengal Health Scheme, 2008

FORM-F

Temporary Family Permit

[*See* sub-clause (9) of clause 10]

1. Name of the Government employee :
2. Employee Identification No. (GPF No.) :
3. Designation :
4. Present Pay (Band pay+ Grade Pay) :
5. Entitlement of accommodation :
6. Date of birth :
7. Date of Superannuation :
8. Residential address :

9. Details of Family :

Sl. No.	Name	Age	Relationship	Monthly Income, If any.	Photograph (Stamp size)
1.					
2.					
3.					
4.					
5.					

Shri/Smt. _____attached to _____ _____ (office) under _____ Department has been enrolled under the West Bengal Health Scheme, 2008 with effect from _____

He/She and his/her family members are entitled to the medical attendance and treatment in a Government Hospital/empanelled Private Hospital or Institution etc. recognised under the West Bengal Health Scheme, 2008 in the entitled class mentioned in Sl. No. 5.

This permit is valid for 6 (six) months from the date of enrolment.*

The temporary family permit is valid till the New entrant Government employee gets G.P.F. No.*

Signature of Cadre controlling authority
/Head of the office.

* Strike out whichever is not applicable.