Form - C1

Reimbursement for cost of Out-Door Patient (OPD) treatment in Recognised/Empanelled /Enlisted Hospital Under West Bengal Health Scheme

(As per Order No.127-F(MED)WB, dated 26.11.2021)

(Generated by Employee from Health Portal)

To

The DIVISIONAL FIRE OFFICER

P-41/42 WILLIAM KERRY SARANI
2ND FLOOR, LALBAZAR FIRE STATION, KOLKATA700001

Sir / Madam,

I am submitting a claim of Rs. 9820 (Rupees. Nine Thousand Eight Hundred and Twenty) towards reimbursement for cost of Out-Patient Department (OPD) treatment at recognised / empanelled / enlisted hospital under West Bengal Health Scheme as per details stated below:

Part-I[General Information]

1. Details of Employee.			
Full Name	PRALAY CHATTERJEE	HRMS ID	2008004236
Enrolment ID No.	WB/EMP/06/000144020	Claim Application ID	E20231020472
Bed Entitlement	GENERAL	Date of Enrolment	01/02/2012

2. Details of Patient, Treating Hospital and Condonation Requirement, if any.		
2.1	Name of Patient	CHAINA CHATTERJEE
	Beneficiary ID	MISC/WB/38083/5/6
	Relationship with Employee	MOTHER
2.2	Name of Recognised/Empanelled/Enlisted hospital where treatment is availed.	NARAYAN MEMORIAL HOSPITAL
	Code of Hospital	0411087
	Class of Entitlement of Hospital	Class-1
	Address of Hospital	85,DIAMOND HARBOUR ROAD, KOLKATA-700034
2.3	Requirement of approval of delay Condonation, if any	YES

3.Details of Claimant *(Applicable in case of death of employee)*		
Sl. No.	Name of Claimant	Relation
3.1		

4.Permission Details, If any		
Sl. No.	Permission sought for	Details of permission approval
4.1	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 [Details and Expenditure Statement of OPD treatment]

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5. Details of OPD Treatment

Sl. No.	Particulars	Details
5.1	Category of OPD Claim (Tick mark in appropriate box) *[See list of diseases/illness mentioned in clause 7 (1) and 7(2)]*	As per clause 7(1) of 7287–F, dated : 19-09-2008
5.2	Name and Nature of OPD Disease/ Illness or follow-up medical attendance and treatment	Neurological Disorder/ Cerebrovascular Disorders , Continuous
5.3	Date of OPD/Follow Up consultation	12/04/2023

6. Expenditure Statement of OPD/Follow Up treatment

Sl No.	Name of Component						Amount Claimed (Rs.)
6.1	**Procedure Charges**						
	Sl No.	Name of Procedure	Procedure Code	Amount Admissible (Rs.)			
6.2	**Consultation Fees**						200
6.3	**Cost of Pathological and Radiological Investigations**						6000
	Sl No.	Name of Investigation	Coded / Non-Coded	Code of Investigation	Amount Admissible (Rs.)		
	1	MRI BRAIN/ BRAIN WITHPROTOCOL/ CSF STUDY/INTERNAL EAR	Coded	02029001	6000		
6.4	**Cost of Medicines**						
	Period of post consultation medicine consumption		From	12/04/2023	To	11/07/2023	3620
6.5	**Cost of Implant / Prosthesis & Special Device**						0
	Sl No.	Name of Implant / Prosthesis & Special Device	Code of Implant / Prosthesis & Special Device	Amount Admissible (Rs.)			
6.6	**Miscellaneous (specify)**						
						Total	9820
						No. of vouchers	4

Net Claim:	
9820	Nine Thousand Eight Hundred and Twenty Only

Part-V [Declaration of Employee]

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I hereby declare that the statements made in the application for claim are 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 enrolment certificate at the time treatment. I will be personally responsible and liable for taking disciplinary action 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 instrument to substantiate my claims in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not (Please Tick)			
1.	**Annexure-I** duly signed with proper stamp by Treating Consultant/Specialist of a Recognised/Empanelled/Enlisted Hospital or copy of duly signed and stamped **Annexure-I (*See notes of annexure-I carefully*).**	Yes	☐	No	☐
2.	Original Money Receipts in chronological dates	Yes	☐	No	☐
3.	Copy of OPD prescription	Yes	☐	No	☐
4.	Copy of Permission grant if any	Yes	☐	No	☐
5.	Original copy of Voucher/ Tax Invoice of Implants purchased	Yes	☐	No	☐
6.	Copy of all investigation/ test reports in sequentially.	Yes	☐	No	☐
7.	Essentiality supported with prescription and audiometric report from treating recognised/empanelled hospital/diagnostic centre ***(Applicable only for claiming reimbursement of Prosthesis and Special Devices).***	Yes	☐	No	☐
8.	In case of death of Employee, a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes Yes Yes	☐ ☐ ☐	No No No	☐ ☐ ☐
9.	Any other instruments (Specify)	Yes	☐	No	☐

Date:

Signature of the Employee/Claimant:

Name in Block Letters :

Designation :