REIMBURSEMENT OF MEDICAL EXPENDITURE IN RESPECT OF ESI BENEFICIARIES

The IMO In-charge,
ESI Dispensary,
……

1. Name of the Patient :
2. Name of the Insured Person :
3. Insurance No. :
4. Name of the employer / company :
5. Relation with the IP :
6. Whether the case was referred : YES / NO (Tick whichever is applicable)
7. If referred, then referral letter No. :
   (copy/original letter enclosed)
8. Referred by :
9. Name of the hospital to which referred :
10. Whether Hospitalized : YES / NO (Tick whichever is applicable)
11. If hospitalized, period of stay :
12. Diagnosis / details of Treatment / Procedure done :
13. Whether the medicines available in the Store : YES / NO (Tick whichever is applicable)
14. Cost of the treatment
    a) Amount paid to the hospital :
    b) Amount paid other than to the hospital :
       (Blood / Ambulance / Test / Medicine) _____
15. Total Amount claimed :
16. Eligibility of the IP / Family :
17. Bank Details
    a) S. B. Account No. | | | | | | | | | | | | | | | |
    b) Name of the Bank :
    c) Name of the Branch :
    d) IFS Code No. | | | | | | | | | | |
       (Please enclose cancelled cheque / photocopy of bank passbook)
18. Whether Statement I & II attached in the prescribed proforma : YES / NO (Tick whichever is applicable)
19. Remarks, if any :
20. Mobile No. :

UNDERTAKING

I undertake that the amount claimed by me in this bill will be recovered in future if it is found false. In such cases, me along my legal heirs will be fully responsible for refund / recovery of the same.

Full Signature of the I.P.

FOR OFFICE USE

01. Name of the Hospital / dispensary :
02. Whether IP is entitled for the benefit :
03. Amount claimed :
04. Amount disallowed :
05. Amount recommended for sanction :

Signature of IMO I/c.

List of Xerox copy of documents submitted by the I.P.

Name of the patient :	
Relation / Name of the I. P.	
Insurance No.:-	
Hospital / Dispensary where attached :	
Disease	
Application of the claimant	
Identity of the patient verified by the treating physician. (Aadhaar Card / Voter Identity Card etc.)	
Temporary Identity Card / e-pehchan card	
Eligibility	
Referred or Not	
Name of the treating hospital	
Treatment period	
Statement I & II from ESI Disp./Hosp.	
Undertaking in Non-Judicial Stamp Paper (Original)	
Essentiality by treating physician	
Bank details	
Date of Discharge from Hospital (in original)	
Legal heir certificate	
No Objection Certificate given by the children above 18 years	
Death Certificate	
Parent Eligibility Certificate (income less than Rs.9000/-)	
Out of Stock Certificate	
Amount claimed	

STATEMENT OF MEDICAL EXPENSES EXCLUDING MEDICINE

STATEMENT-I

	Particulars	Invoice No.	Amount
1.	Charges of the hospital where treated		
2.	Tests / investigations done outside the hospital where admitted		
3.	Ambulance		
4.	Blood Bank		
5.	Implants / appliances		
	Total		

DETAILS OF MEDICINES WITH STATEMENT

STATEMENT-II

Sl. No.	Designation of the treating physician with name of the institution	Particulars of medicines prescribed and purchased				Total Admissible Amount	Total Inadmissible Amount	Remarks
		Cash Memo No.	Name of the Medicines	Qty.	Cost (In Rs.)			
1	2	3	4	5	6	7	8	9

Total expenditure in the hospital = Rs.

Total Cost of Medicines = Rs. _____

Total amount recommended for sanction = Rs._____

Signature of Head of Office with Seal

ESSENTIALITY CERTIFICATE

It is to certify that Sri/Smt./Kum …… Son/Daughter/Father/Mother/Wife of Sri/Smt./Kum..... serving as …….. under the Department/Office of the M/s. …… has been under my treatment for …….. from …….. to ……..…….. at my consulting / Room / Residence of the Patients/Indoor/Outdoor of …… ……. Hospital/Dispensary/RHC/NAC and the under mentioned medicines were essentially necessary for the prevention of the serious deterioration of the patient.

The medicines do not include any of the items in the list of inadmissible medicines and similar preparation reimbursing the cost of which is inadmissible to Govt. Servants and their family members.

Sl. No.	Name of the Medicine	Qty.	Bill No.	Bill Date	Amount (In Rs.)

(N.B. The name of the Medicine or the name of the disease should be written in CAPITAL LETTERS)

Encl. Original Bills

Signature of the AMA with his Seal

I Certify that I was not on leave or under suspension or on deputation to Foreign Service during the period of treatment referred to in the above essentiality certificate.

Signature of the AMA with his seal

Signature of the IP Attested

Check list for submission of reimbursement claim of ESI beneficiaries

Sl. No.	Documents	Check Box (Please tick the boxes, if submitted)
1.	Pehchan Card	
2.	ESI Eligibility Certificate	
3.	Aadhaar Card	
4.	Essentiality Certificate (Original)	
5.	Discharge Certificate (Original)	
6.	Death Certificate (in case of death of patient)	
7.	Statement I & II	
8.	Undertaking in Non-judicial Stamp Paper (Original) *	
9.	NOC from major legal heirs or parents in case of death	
10.	Cancelled cheque or bank statement of the IP	
11.	Cancelled cheque or bank statement of the employer in cases where the employer has incurred the expenditure	
12.	Consent of the IP and legal heir in non-judicial stamp paper where employer has incurred the expenditure. (Original)	
13.	Out of stock certificate in case of non-availability of medicine in ESI Dispensaries.(Original)	
14.	Parents eligibility certificate (income less than 9000/- per month)	

* Undertaking of the IP in Non-judicial stamp paper that “I have not received the claim from the employer, State Treatment Fund (STF) / Rashtriya Swasthya Bima Yojana (RSBY) / Biju Krushak Kalyana Yojana (BKKY) or any other insurance agencies and if subsequently it is found that I have received / claimed the amount from any other agency, then the amount paid will be recovered from me or my legal heir(s)”.