GOVERNMENT OF NATIONAL CAPITAL TERRITORY OF DELHI
LABOUR DEPARTMENT
ADMINISTRATION BRANCH
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F.1/31/LC/996/Estt./Misc./2019/3218 **Date:** 01/09/2021

CIRCULAR

Sub: Procedure for submission of Medical Bills for Re-imbursement.

It is to inform that for smooth disposal with a motive to increase the transparency and avoid any kind of discrepancy in the process vis-a-vis disposal of medical bills re-imbursement cases, a Bill Summary Proforma (copy enclosed) duly filled by the claimant needs to be attached alongwith the medical bills re-imbursement claim prior to submission in the department.

Therefore, all the DGEHS pensioners/serving beneficiaries are hereby advised to submit the Medical Bill Re-imbursement Claim (**IN TRIPLICATE**), separately for each beneficiary, in prescribed format and in chronological order as appended here below henceforth:

1. Annexure-I : Check List for Re-imbursement of Medical Claims (Copy enclosed)
2. Annexure-II : Revised Medical 2004 Form (Copy enclosed)
3. Copy of Medical Card
4. Duly filled Bill Summary Proforma
5. OPD Consultation Voucher (if applicable)
6. OPD Prescription/IPD detailed bill summary
7. Emergency Certificate (in case of Non-empanelled hospital)
8. N/A Certificate from attached dispensary/hospital
9. Medicine and Investigation Vouchers/Bills (in original)
10. Updated RTGS details (for retiree claimants)

(* All documents mentioned above should be self attested.)

Rana

(ANITA RANA)
DY. LABOUR COMMISSIONER (ADMN)/H.O.O

Encl: As above.

F.1/31/LC/996/Estt./Misc./2019/3218 **Date:** 01/09/2021

Copy to:

1. All branch In-charges and District heads of Labour Department, GNCTD for circulation amongst all officials of respective branch/district.
2. System Analyst, EDP Cell with the request to upload this circular on the website of the department.

Rana

DY. LABOUR COMMISSIONER (ADMN)/H.O.O

ANNEXURE-I

DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME
MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. DGEHS Card No. and Place of Issue: -
2. Validity of DGEHS Card from……to……..
3. Ward Entitlement (if Admitted in Hospital): - Private. / Semi Private. / General
4. Full Name of Employee/Beneficiary (Block Letters):-
5. Designation:-
6. The following documents are submitted: - (Please tick (√) the relevant column)

a) Revised Medical 2004 Form:- Yes/No

b) Photocopy of DGEHS Card showing validity (Emp. /Patient): - Yes/No

c) Photocopy of Referral/ Authorization form AMA:- Yes/No

d) Original Bills: - Yes/No

e) Copy of prescription for OPD cases / Discharge Summary for Indoor cases:- Yes/No

f) Breakup for Lab Investigation:- Yes/No

g) Breakup of Drugs prescribed:- Yes/No

h) Emergency Certificate from Hospital Empanelled / Registered with Government in case of Emergency Admission: - Yes/No

i) Self explanatory letter showing the need of emergency visit (in emergency cases): - Yes/No

j) Non Availability Certificate from AMA (attached Dispensary / Hospital) for drugs prescribed in OPD's :- Yes/No

k) Original papers have been lost the following Documents are submitted: - Yes/No

   i. Photocopies of Claim Papers:- Yes/No
   ii. Affidavit on Stamp Paper: - Yes/No

l) In case of Death of Card Holder the following Documents are submitted:- Yes/No

   i. Affidavit on Stamp Paper by Claimant: - Yes/No
   ii. No objection from other legal Heirs on Stamp paper :- Yes/No
   iii. Copy of Death Certificate:- Yes/No

7. Name of the Bank…….Branch……..…SB A/C No…….....

Branch MICR Code……IFS Code……. Tel. No. of Bank Branch…….

Dated:-

Signature of DGEHS Card Holder

Telephone No. (M)…… (O)….……E-Mail ID:-……

Note: -
1. Kindly enclose Photocopy of Cancelled Cheque for online transfer of many to the account of beneficiary.
2. Provide one original copy and two photocopies of complete set of claim.

ANNEXURE-II

DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME

REVISED MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF DGEHS BENEFICIARIES

(To be filled by the claimant)

1. DGEHS Card No. and Place of issue:-

2. Validity of DGEHS Card: - from……to……..

3. Ward Entitlement (if Admitted in Hospital): - Private. / Semi Private. / General.

4. Full Name of Employee/Beneficiary (Block Letters):- Mr./Ms.

5. Full Address:--

6. Telephone No. (O)……..…… (M)……..……

7. E-mail Address if, any:

8. Name of the Bank…….Branch……..…SB A/C No…….....

Branch MICR Code…….IFS Code……. Tel. No. of Bank Branch…….

9. Name of the Patient & Relationship with the Card Holder:-

10. Basic Pay (Excluding Grade Pay):-

11. Name of the Hospital with Address:-

(a) OPD Treatment (Investigations) & Period of treatment:-

(b) Indoor Treatment:- Date of Admission……Date of Discharge…….....

12. Total Amount Claimed: - Total Rs.

Total Amount Claimed	Consultation Charges	Investigation Charges	Medicine Charges	Other Charges
For OPD Treatment				
For Indoor Treatment				

13. Details of Referral:-

14. Details of Medical Advance if, any:-

DECLARATION

I hereby declare that 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 dependant on me. I am a DGEHS beneficiary and the DGEHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated:-

Signature of DGEHS Card Holder

Note: Misuse of DGEHS facilities is a criminal offence. Suitable action including cancellation of DGEHS card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.

BILL SUMMARY PROFORMA FOR MEDICAL RE-IMBURSEMENT

Medical Re-imbursement in respect of :	
Relation with claimant:	
Name of treating hospital:	
Address of treating hospital:	
Empanelled or Non-Empanelled:	
Date/Period of treatment:	

Sr. No.	OPD/ Investigation/ Medicine/ Others	Invoice No.	Date	Rates Charged by the Hospital	DGEHS Code of Investigation/ Procedure (Office Use)	DGEHS approved rates (Office Use)	Restricted Claim Amount by Administration Branch (Office Use)	Restricted Claim Amount by Accounts Branch (Office Use)	Remarks, if any (Office Use)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

*** All the details of medical bill claim in above Proforma should be filled by the DGEHS beneficiary except the column specified for office use.**

Signature of DGEHS Card Holder

SECTION OFFICER
(ADMINISTRATION BRANCH)

DDO/AAO