Government of West Bengal Department of Health & Family Welfare MERT Branch Swasthya Bhawan, Block – GN – 29, Salt Lake City, Sector – V, Kolkata -91.

NOTIFICATION

No. HF/O/MERT/594/HFW-24011(13)/2/2020

The Governor is hereby pleased now to provide the benefits of "West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Department of Health & Family Welfare, Government of West Bengal" to the serving Teachers including Librarians and Graduate Laboratory Instructors of the College of Medicine and JNM Hospital, Kalyani and Officers of the West Bengal University of Health Sciences, Salt Lake, Kolkata under Department of Health & Family Welfare, Government of West Bengal and the family members in the following manner under the scheme detailed below.

Dated: Kolkata, the 21st June, 2021

Scheme

- 1. Short title and commencement (1) This Scheme may be called "West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Department of Health & Family Welfare, Government of West Bengal".
- 2. **Application** (1) This scheme shall apply to the serving Teachers including Librarians and Graduate Laboratory Instructors of the College of Medicine and JNM Hospital, Kalyani and Officers of the West Bengal University of Health Sciences under Department of Health & Family Welfare and their dependent beneficiaries.
- (2) The provision of enrolment under this scheme shall be optional.
- (3) This scheme will be implemented in reimbursement mode only.
- (4) A teacher/officer shall not be entitled to draw the regular medical allowances, if opted for this scheme with effect from the date of effect of such enrolment.
- (5) A teacher/officer has the liberty to opt out from the scheme by applying through WBHS portal using his/her individual login. Provided that a teacher/officer shall not be allowed to opt out from scheme within five years from the month following the month in which s/he or his/her beneficiary enjoyed the benefit under the scheme.

- 3. **Definitions** In this scheme unless there is anything repugnant in the subject or context.
- (a) "Approved Rates" means such rates as may be notified by Finance Department, Government of West Bengal applicable for West Bengal Health Scheme from time to time for various services, procedures and investigations required in connection with the medical attendance and treatment of a beneficiary.
- (b) "Beneficiary" means a serving teacher/officer with his/her dependent member of the family.
- (c) "Clause" means a clause of the scheme.
- (d) "Institutions" means the West Bengal University of Health Sciences including College of Medicine and JNM Hospital, Kalyani.
- (i) "Head of Institution" means the Vice-Chancellor of the West Bengal University of Health Sciences.
- (ii) "Recommending Authority" means any officer having rank in the middle tier of the Institution.
- (iii) "Operator" means any clerical staff (LDC/UDC) of the Institution.
- (e) "Administrative Department" means Department of Health & Family Welfare, Government of West Bengal.
 - (i) "Head of the Department" means Addl. Chief Secretary/Principal Secretary/Secretary of the Administrative Department.
 - (ii) "Delegated Approver" means an officer up to the rank of Joint Secretary of the Administrative Department.
- (iii) "Verifying Authority" means any DS/ AS/ Registrar/ SO/ Assistant/Clerk (UDA/ UDC/ LDA/ LDC) of the Administrative Department.
- (f) (i) 'Teacher' means full time and regular serving Teachers including Librarians and Graduate Laboratory Instructors of the College of Medicine and JNM Hospital, Kalyani and the West Bengal University of Health Sciences under Department of Health & Family Welfare, Govt. of West Bengal enrolled under clause 2.
 - (ii) "Officer" means serving officers of the West Bengal University of Health Sciences under Department of Health & Family Welfare, Government of West Bengal and College of Medicine and JNM Hospital, Kalyani under West Bengal University of Health Sciences.
- (g) "Family" in relation to a teacher/officer includes the following;
- (i) Husband or Wife as the case may be,
- (ii) Dependent Parents whose monthly income does not exceed rupees three thousand and five hundred.
- (iii)Dependent Children including step-children, legally adopted children up to the age of 25 years.
- (iv)Dependent widowed/divorced daughters whose age exceeds 25 years but her monthly income does not exceed Rupees one thousand and five hundred.
- (v) Dependent Minor brothers and sisters up to the age of 18 years.
- (vi)Dependent unmarried/widowed/divorced sisters whose age exceeds 18 years but her monthly income does not exceed Rupees one thousand and five hundred.
- (vii) Income (not age) shall not be a consideration when the eligible beneficiaries mentioned with sl. no. (ii) to (vi), stated above are suffering from Critical Illness/Disease as notified by Finance Department, Govt. of West Bengal vide order No. 54-F (MED) WB dt. 22.07.2019.

Note:

- 1. The conditions of beneficiary are not applicable to the spouse. Spouse can be included irrespective of his/her monthly income. But....
 - a. If both husband or/and wife is/are working/worked in any organisation under direct control of Govt. of West Bengal and is/are eligible to draw Medical Allowance/Relief, they can enrol themselves individually or jointly to their respective health scheme controlled by their Administrative Department. In case of opting in a health scheme jointly in a particular scheme, only the benefit of that scheme is admissible.
 - b. Again if the spouse is an employee of Central Govt. or PSU Bank or any Corporation/Undertaking, financed more than 50% total capital by Central/State Govt. or local bodies or aided institution or private organisation which provides medical facility, s/he to choose any one place for getting medical facility. Therefore, if spouse wants to get benefits under this scheme, an official certificate from his/her employer is to be produced first regarding relinquishment of medical allowance and benefit available from his/her employer.
- 2. 'Son' is considered to be dependent till he starts earning or attains the age of 25 years, whichever is earlier. Son suffering from permanent disabilities either physically or mentally will be considered dependent without any age limit.
- 3. Unmarried daughter is eligible till she starts earning (irrespective of age).
- 4. Son/daughter/sister shall not be considered as beneficiary from the date of their marriage.
- 5. As an exception, parents can live away from employee in another station with other members of family.
- 6. A declaration regarding the income of all dependent beneficiaries except spouse shall be furnished biennially by the concerned enrolled teacher/officer in the month of November.
- (h) 'Order' means all orders issued by Finance Department, Govt. of West Bengal in connection with implementation of West Bengal Health Scheme in **reimbursement mode** applicable for employees of Govt. of West Bengal and it will be equally applicable for this scheme also.
- (i) "Form" means a Form appended to this scheme.
- (j) "Government" means Govt. of West Bengal.
- (k) "Health Care Organisation (HCO)" means such Govt. or Private Hospital/Nursing Home that may be recognized/empanelled/enlisted from time to time by Finance Department, Govt. of West Bengal for the purpose of availing benefits of medical attendance and treatment under West Bengal Health Scheme.
- (l) "Laboratory" means such laboratory as may be recognized by the Govt. of West Bengal from time to time for availing of benefits of medical attendance and treatment under this scheme.
- (m) "Medical attendance" means for professional advice and includes pathological, bacteriological, radiological or other methods of investigation for the purpose of diagnosis which are considered necessary by the attending physician and are carried out in a hospital.
- (n) "Specified" means specified by order.
- (o) "Treatment" means the use of medical and surgical facilities and includes-
 - (i) The employment of such pathological bacteriological, radiological or other methods of investigations which are considered necessary by the attending physician.
 - (ii) The use of such medicines, vaccines, serum or other therapeutic substances as may be considered necessary by the attending physician.
 - (iii) Medical and surgical services and procedures.

- (iv) Dental treatment.
- (v) Such nursing as is ordinarily provided at the hospital or such special nursing at the hospital as the authorized medical attending physician at the hospital may certify, in writing, to be essential for the recovery or for the prevention of serious deterioration in the condition of the patient, having regard to the nature of the disease.
- 4. **Facilities** A teacher/officer and his/her dependent beneficiary shall be entitled to get the following facilities, namely:-
 - (a) Medical attendance and treatment as an indoor patient in a hospital.
 - (b) Medical attendance and treatment as an Out-Patient Department (OPD) patient in a recognised/empanelled/enlisted hospital, or a clinic attached to such hospital for the diseases specified by competent authority from time to time.
- 5. Medical attendance and treatment as an indoor patient in a hospital A teacher/officer shall be entitled to get reimbursement of the cost of medical attendance and treatment of him/her and his/her dependent beneficiary's, as an indoor patient in a hospital.

Explanation – For the purpose of the clause the expression "cost of medical attendance and treatment" shall include-

- (a) The amount charged by the hospital in accordance with the approved rates notified by Finance Department, Govt. of West Bengal.
- (b) The cost of medicines supplied by the recognised/empanelled/enlisted or purchased from outside on the advice of the attending physician of the hospital provided that the certification of Medical Superintendent on non-availability of such medicine in the store of hospital.
- (c)The charges for such pathological, bacteriological, radiological or other methods/investigations as are considered necessary by the attending physician and carried out, on the advice of the attending physician, in a recognised/empanelled/enlisted hospital/diagnostic centre other than the treating hospital.
- (d) The cost of Implants and/or Special Devices as prescribed by the treating surgeon/consultant of a hospital where the treatment is going on is reimbursable as per approved WBHS rate or actual basis in case where no prescribed rate exists.
- (e)The cost incurred on account of related medical attendance and treatment received in recognised/empanelled/enlisted hospital during the period up to 30 days prior to hospitalization and 30 days from date of discharge.

6. Medical attendance and treatment as an OPD (Out-Patient Department) patient in a hospital-

- (1) A teacher/officer shall be entitled to get reimbursement of the cost of medical attendance and treatment of him/her and his/her dependant beneficiary's as an OPD patient in recognised/empanelled/enlisted hospital in the following diseases:
 - (i) Malignant diseases (Mainly cancer cases are considered as malignant diseases)
 - (ii) Tuberculosis.
 - (iii) Hepatitis B/C and other liver diseases.
 - (iv) Insulin-dependent diabetes. (Type 2 Diabetes Mellitus is not considered as Insulin- dependent Diabetes)

- (v) Heart diseases.
- (vi) Neurological disorders/ Cerebrovascular disorders.
- (vii) Malignant Malaria.
- (viii) Renal failure.
- (ix) Thalassemia/ Bleeding disorders/ Platelet disorders.
- (x) Injuries caused by accidents. (Animal Bite cases will come under the purview of injuries caused by the accidents.)
- (xi) Rheumatoid Arthritis.
- (xii)Systematic Lupus Erythematosus (LUPUS)
- (xiii) Crohn's Disease.
- (xiv) Endodontic Treatment (Root Canal Treatment).
- (xv) Chronic Obstructive Pulmonary Disease (COPD).
- (xvi) Ankylosing Spondylitis.
- (xvii) None of the above list [Vide para 10 of 797-F(MED), dated 31.01.2011]
- (2) A teacher/officer or his/her beneficiary shall also be entitled to get reimbursement of the cost of follow-up medical attendance and treatment relating to Neuro-Surgery, Cardiac Surgery (including Coronary Angioplasty and implants), Cancer Surgery/ Chemotherapy/Radiotherapy, Renal Transplant, Hip/Knee replacement Surgery and Accident cases received as an OPD patient in recognised/empanelled/enlisted hospital.

Explanation – For the purpose of this clause the expression "cost of medical attendance and treatment" shall include:

- (a) The amount charged by the recognised/empanelled/enlisted hospital in accordance with the approved rates.
- (b) The cost of medicines purchased from outside on the advice of the attending physician of the recognised/empanelled/enlisted hospital.
- (c) The charges for such pathological, bacteriological, radiological or other methods of investigations as are considered necessary by the attending physician and carried out on the advice of the attending physician in a recognised/empanelled/enlisted hospital or laboratory other than the hospital in which the patient is treated.
- (d) The cost of Implants and/or Special Devices as prescribed by the treating surgeon/consultant of a recognised/empanelled/enlisted hospital where the treatment is going on is reimbursable as per approved WBHS rate or actual basis in case where no prescribed rate exists.

7. Enrolment:

- (a) A teacher/officer will have to apply online for enrolment under "West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Department of Health & Family Welfare, Govt. of West Bengal" through West Bengal Health Scheme Portal having URL https://wbhealthscheme.gov.in. New URLs will also be available within the portal for West Bengal University of Health sciences.
- (b) At the time of online application, Teacher/Officer has to upload scanned clear photo and signature having size 12-50 kb of all beneficiaries besides other mandatory information. After online submission, s/he has to take a print out of the submitted form and it has to be submitted physically to the Head of the Institution attaching all necessary documents like Birth Proof, Blood Group, Aadhar Card, Income Certificate and any other documents that are required to substantiate the inclusion of beneficiary.

After receiving both soft and hard copy (attached with other instruments), Operator will check it carefully. If s/he detects any error, s/he will modify it. Then Operator will forward it to Recommending Authority. The Recommending Authority will check it again. S/he can modify mistakes or can return it to Operators. Then the Recommending Authority will forward the application to the Head of the Institution for necessary approval. Finally Head of the Institution will approve the application if s/he finds it correct with his/her registered class 2/3 Digital Signature Certificate (DSC).

After getting message from WBHS portal, incumbent will take print out of approved enrolment certificate from WBHS portal after creating his/her individual login. No one except Head of the Institution can approve his/her own enrolment certificate.

The Administrative Department has no role in enrolment procedure.

(c) On successful enrolment under the health scheme, the drawl of regular medical allowance shall be discontinued from the date of effect mentioned in approved enrolment certificate.

8. Criteria for Reimbursement of Claims:

- a. Enrolled teachers /officers will get the facility of OPD/IPD medical treatment in Govt. Hospitals, Hospitals managed by local bodies like municipalities, State-Aided Hospitals, Speciality/Enlisted Hospitals outside the state and Empanelled Private Hospitals as listed in Finance Department's Notification No. 3473-F dt. 11.05.09, and as amended from time to time. List of such HCOs will be available in the WBHS Portal.
- b. The beneficiaries under this health scheme may also avail the only indoor medical treatment facilities in any non-empanelled private hospital/nursing home. Reimbursement of the cost of such indoor medical treatment is admissible under this scheme as per orders issued by Finance Department, Govt. of West Bengal.
- c. For availing treatment in enlisted hospitals outside West Bengal, notification of Finance Department, Govt. of West Bengal shall be adhered strictly in this regard.

9. Accommodation/Entitlement:

(a) In the case of medical attendance and treatments as an indoor patient in a Pay Bed of Govt. Hospital or Tata Medical Center, Rajarhat or Other Private Empanelled Hospital, a teacher/officer or his/her beneficiary shall be entitled to avail the following accommodation as tabled below:

Sl.	Category	Range of Basic	Type of Accommodation
No.	of	Salary as per	
	Beneficiary	ROPA-2019	
1	I	Rs.1,50,000/-	i)Pay Bed in Govt. Hospitals: Single Occupancy Large
		& More.	Cabin
			ii)Tata Medical Center, Rajarhat: Private Bed
			iii) Other Private Empanelled HCOs: Deluxe Room/
			Executive Room or Executive Cabin/ Executive Private Cabin.

2	II	Rs. 75,000/- &	i)Pay Bed in Govt. Hospitals: Single Occupancy Small Cabin
		more but less	
		than Rs.	ii)Tata Medical Center, Rajarhat: General Bed
		1,50,000/-	
			iii)Other Private Empanelled HCOs: Private Room/ Private
			Cabin /Private Bed
3	III	Rs. 45,000/- &	i) Pay Bed in Govt. Hospitals: Double Occupancy Large
		more but less	Cabin
		than Rs.	
		75,000/-	ii)Tata Medical Center, Rajarhat: General Bed
			·
			iii)Other Private Empanelled HCOs: Semi-Private Bed

10. Financial Power of sanctioning claim:

Financial power for sanctioning the cost of medical attendance and treatment for IPD and OPD treatment is given below:

Approving Authority	Financial Power		
	Indoor Treatment	OPD	
Head of the Administrative Department (Addl. Chief Secretary/Principal Secretary/Secretary) for both College & University.	Ful	l Power	
Delegated Approver of the Head of the Administrative Department up to the rank of Joint Secretary.	Rs. 1.00 Lakh	Rs. 10,000/-	

11. Settlement of Reimbursement Claims:

- (i) Enrolled Teacher/Officer will submit reimbursement claim using his/her individual login through West Bengal Health Scheme Portal. After online submission, s/he has to take a print out of submitted form and it has to be submitted physically to Head of Institution attaching all necessary documents like money receipts, annexure, all treatment documents and any other instruments that are required to substantiate the claim.
- (ii) After receiving both hard and soft copy (attached with other instruments), Operator will check it carefully. If s/he detects any error, s/he will modify it. Then Operator will forward it to Recommending Authority. The Recommending Authority will check it again. S/he can modify mistakes or can return it to Operators. The Recommending Authority will forward the correct application to the Head of Institution. Head of Institution will forward the claim to Administrative Department for necessary approval.
- (iii) On receiving both soft and hard copy of reimbursement claim, The Verifying Authority of the Administrative Department will check it again. Once s/he finds the claim in correct way, s/he will forward it to the Delegated Approver of the Administrative Department (in the rank of Joint Secretary and above).
- (iv) On checking the claim, if the admissible amount is within the ceiling of Delegated Approver of the Administrative Department, s/he will approve it and generate sanction order with his/her registered Digital Signature Certificate (DSC). Delegated Approver of the Administrative Department will forward the claim to Head of the Department (Addl. Chief Secretary/Principal Secretary/Secretary) for approval if the admissible amount exceeds the ceiling delegated to him/her.

- (v) Head of the Department will approve the claims those are forwarded by the Delegated Approver of the Administrative Department. Registration of DSC by Head of the Department is not mandatory. S/he can approve and generate sanction order against a claim with his/her registered DSC. When Head of the Department approves claim without DSC, Delegated Approver needs to generate sanction order with his/her registered DSC mandatorily.
- (vi) In all sanctioned claims, Administrative Department shall make necessary arrangement of stamping of "Paid and Cancelled" and signature by competent authority in all vouchers of such claim. The Administrative Department shall allocate necessary allotment to DDO of Head of the Institution for submission of claim to linked Pay and Accounts Officer/Treasury.
- (vii) After getting, DSC enabled sanction order and vouchers from competent authority, Operator of University/Department will prepare **Treasury Bill** in TR-31A in WBHS Portal and forward it to DDO for subsequent submission in WBIFMS (E-Billing module). Again DDO has to submit the said **Treasury Bill** using his/her registered DSC to linked Pay &Accounts office/ Treasury accessing his/her login in WBIFMS Portal without attaching any vouchers and beneficiary list.
- (viii) No physical voucher is required to be attached at the time of submission of bill to Treasury as per existing provision. All vouchers shall be preserved in College/ University for the purpose of future audit. Only DSC enabled sanction order shall be attached with **Treasury Bill** in TR Form 31A at the time of drawal of claim to Pay and Accounts Officer/Treasury.
- (ix) Moreover, for settling a claim, notification no. 3474-F dt. 11.05.2009, 796-F(MED) dated 31.01.2011, 797-F(MED) dated 31.01.2011, 11253-F(MED) dated 16.11.2011, 796-F(MED) dated 19.09.2013 and other related order issued by Finance Department, Govt. of West Bengal shall be adhered strictly.
- (x) List of inadmissible items, viz. Foods, Tonics, Medicines etc shall be guided as per Finance Department (Medical Cell) Memorandum No. 6586-F(MED) dated 29.06.2011.

The Forms of enrolment & reimbursement of claims along with the prescribed format for approval, recommendation and sanction of claim are annexed hereto.

Sl. No.	Form No.	Subject					
1	Form -A	Application of Enrolment					
2	Form-B	Certificate of Enrolment					
3	Claim Forms	HF GIA Form C1 to C5					
4	Form-R	Format of Sanction Order					
5	Annexure-I	Essentiality Certificate for claiming OPD					
		Reimbursement					
6	Annexure-II	Essentiality Certificate for claiming IPD Reimbursement					
		for availing treatment on Non-Empanelled Hospital or					
		Institution					

12. Treatment in a hospital or institution outside the State:-

(i) Notwithstanding anything contained elsewhere in this scheme, the Government may recognize specialized hospitals and institute outside the State for treatment of specific diseases. All hospitals, situated outside West Bengal and notified by Finance Department, Govt. of West Bengal shall have to consider in this case. Treatment cost in case of availing treatment in a hospital outside West Bengal other than enlisted shall not be eligible for reimbursement.

- (ii) Prior approval from Addl. Chief Secretary/Principal Secretary/Secretary of Department of Health & Family Welfare shall be obtained for receiving medical attendance and treatment in these enlisted hospitals outside West Bengal. In case of technical opinion from doctor, Administrative Department may consult with West Bengal Health Scheme Authority (WBHSA) before final approval.
- (iii) Claim for reimbursement of the cost of medical attendance and treatment in these hospitals shall be allowed on actual basis of various services provided by and investigations and procedures carried out by these hospitals only in the course of treatment.
- (iv) Cost of inadmissible items mentioned in different notifications issued by Finance Department, Govt. of West Bengal is not allowed for reimbursement.
- **13. Medical Advance** (i) The sanctioning authority for reimbursement of the cost of medical attendance and treatment may grant medical advance on submission of a certified estimate from the hospital in which medical attendance and treatment is received as an indoor patient.
- (ii) The advance shall not exceed 80 percent of the estimated cost of medical attendance and treatment.
- (iii) The medical advance shall be adjusted against the admissible cost of medical attendance and treatment, excess, if any, shall be refunded by the employee. If medical attendance and treatment is not received within 60 days of receipt of medical advance, the entire advance shall be refunded by the employee on the expiry of this period.
- (iv) All other orders issued by Medical Cell, Finance Department, Govt. of West Bengal from time to time regarding drawl of medical advance for medical attendance and treatment is equally applicable for this scheme also.

14. Timeline for reimbursement claim submission -

- (i) Beneficiary has to submit his/her reimbursement claim under "West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Department of Health & Family Welfare, Government of West Bengal" within 6 (Six) months from date of discharge (for In-patient Department) or date of consultation (for Out-Patient Department).
- (ii) No one will be allowed to get reimbursement under "West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under Department of Health & Family Welfare, Government of West Bengal" against any claim submitted after 2 (Two) years from date of discharge (for In-patient Department) or date of consultation (for Out-Patient Department) under normal circumstances.
- (iii) All other orders issued by Medical Cell, Finance Department, Govt. of West Bengal from time to time regarding timeline for reimbursement claim submission is equally applicable for this scheme also.
- **15. Operational Guidelines clarifications, etc.** (i) The Department of Health & Family Welfare in consultations with the Finance Department (Medical Cell), wherever necessary, shall issue operational guidelines clarifications, etc. for implementation of the scheme.

- (ii) If any difficulty arises in the course of implementation of the scheme, it shall be referred to the Finance
 Department (Medical Cell) and the decision of the Finance Department (medical Cell) thereon shall be final.
 - (iii) Further operational guidelines in this regard, if required, will be issued later on.
 - 16. The Head of Account for allotment of fund for medical reimbursement: "24-2210-Medical and Public Health-05-MEDICAL EDUCATION, TRAINING AND RESEARCH-105-Allopathy-074-Medical Reimbursement to the Teachers and Officers of State aided Universities-31-Grants-in-aid-GENERAL-02-Other Grants-V".
 - 17. The Annexure prescribing the Forms of Enrolment and Reimbursement of Claims will be available in the Website.
 - 18. This Order is issued with the concurrence of Finance Department, Govt. of West Bengal vide their U.O. No. E-366-F(Med) dt. 18/05/2021 read with UO NO: Group O/2021-2022/0032 UO Date: 17/06/2021.
 - 19. All concerned are being informed.

By order of the Governor

Special Secretary to the Govt. of West Bengal Dated: Kolkata, the 21st June, 2021

No. HF/O/MERT/594/HFW-24011(13)/2/2020/1(10)

Copy forwarded for information and necessary action to:

- 1. Accountant General (A&E), West Bengal, Treasury Building, Kolkata -700001.
- Principal Accountant General (Audit) West Bengal, Treasury Building Kolkata 700001.
- 3. The Joint Secretary, Finance Department (Medical Cell), Govt. of West Bengal.
- 4. The Joint Secretary, Finance Department, Group-O, Govt. of West Bengal.
- The Joint Secretary, Finance (Budget) Department, Govt. of West Bengal.
- 6. Pay & Accounts Officer, Kolkata Pay & Accounts Office I, 81/2/2 Phears Lane, Kolkata 700073.
- 7. Pay & Accounts Officer, Kolkata Pay & Accounts Office II, Hyde Lane Kolkata 700073.
- Pay & Accounts Officer, Kolkata Pay & Accounts Office III, IB Market, 1st floor Sector III, IB Block, Kolkata – 700106.
- 9. The Treasury Officer, Kalyani Treasury, P.O.- Kalyani, Dist.- Nadia.
- 10. Finance Officer, the West Bengal University of Health sciences.

Special Secretary

No. HF/O/MERT/594/HFW-24011(13)/2/2020/2(15)

Dated: Kolkata, the 21st June, 2021

Copy forwarded for information and necessary action to:

- 1. Vice-Chancellor, the West Bengal University of Health sciences.
- 2. The Director of Medical Education, Dept. of Health & Family Welfare, Govt. of West Bengal.
- 3. The Director of Health Services, Dept. of Health & Family Welfare, Govt. of West Bengal.
- 4. Special Secretary, Medical Reimbursement Cell, Swasthya Bhawan, Kolkata.
- The Joint Secretary, Medical Education Branch, Dept. of Health & Family Welfare, Govt. of West Bengal.
- 6. The Principal, College of Medicine and JNM Hospital, Kalyani.
- 7. The Controller, the West Bengal University of Health sciences.
- 8. The Registrar, the West Bengal University of Health sciences.
- 9. The MSVP, College of Medicine and JNM Hospital, Kalyani.
- The Deputy Secretary, Medical Education Branch, Dept. of Health & Family Welfare, Govt. of West Bengal.
- 11. The PA to Hon'ble CM & MIC., Dept. of Health & Family Welfare, Govt. of West Bengal.
- 12. The PA to Hon'ble MOS., Dept. of Health & Family Welfare, Govt. of West Bengal.
- The PA to the Secretary, Health and Family Welfare Department, Swasthya Bhavan, Govt. Of West Bengal, Salt Lake, Kolkata – 700091.
- 14. IT cell of the Dept. with request to place it in Website.

15. Guard File.

Special Secretary

FORM A Application for Enrollment

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То							
The .			(De	esignation of He	ad of Instit	ution)	
			(N	lame of the Inst	itution)		
			(0	Office Address o	f Head of Ir	nstitution)	
			•			•	
I, Sri,	/Smt./Miss		(Name o	f Teacher/Office	er)	(Designation) do
for co	oming under West Be	engal Healt	h Scheme for	the Beneficiari	es of Grant	-in-Aid Colle	eges and Unive
Depa	rtment of Health & F	amily Welf	are, Govt. of	West Bengal w	ith effect f	rom	
The	particulars of me are	e stated he	rein under:				
SI.		Partio	culars			Detai	ls
No.							
1	Name of Teacher/Offi	cer					
2	Application ID						
3	Designation						
4	Gender						
5	Marital Status						
6	Residential Address						
7	Date of Birth						
8	Date of Entry into Uni						
9	Date of Superannuation						
10	Basic Pay/Basic Salary		A 2009 or 201	9)			
11	DDO Code of Head of	Institution					
12	Mobile No.						
13	E-Mail Address						
14	Voter Card/ PAN/Aad						
15	Bank details for claim	disburseme	nt				
D-4-							
рета	ils of eligible family m	iembers inc	iuding me are	e given below:			
CI	Name	Data of	Dalation	Donofisia:::	Dlood	Dhata	Cianatura
SI.	Name	Date of	Relation	Beneficiary	Blood	Photo	Signature
No.		Birth		ID	Group		
	1	1	1	1	1		1

I do hereby declare that upon enrollment under the above scheme, I shall forgo the regular Medical Allowance drawn by me as a part of salary and abide by the provision of the scheme issued by competent authority.

Enclo: Copy of Pay slip, proof of Identity & blood group of all beneficiaries and declaration of income of all eligible beneficiaries.

Signature of Teacher/Officer: Designation:



HEALTH AND FAMILY WELFARE DEPARTMENT THE WEST BENGAL UNIVERSITY OF HEALTH SCIENCES DD-36, Sector-I, Salt Lake, Kolkata 700064

Certificate for Enrollment under WBHS for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health and Family Welfare, Govt. of West Bengal

Reimbursement Only

Memo	oNo.					Date:	
Info	rmation of Teache	r/ Officer					
1.	Name (In Block Letter)				2.	Enrolment ID.	
3.	Designation of Teacher/				4.	Date of Entry into College/University	
5.	Address of Teacher/ Offi	icer			6.	Date of Superannuation	
Hos	pital Accommodat						
1.	Pay Bed in Government		y Govt. of West I	Bengal			
2.	Tata Medical Centre, Ra						
3.	Other Private Empanelle						
Info	rmation of Benefic	ciaries (Inc	luding Teac	her/ Officer	r)		
1.	Name of Beneficiary	Beneficiary ID: Relation With Teacher/ Officer: Date of Birth: Blood Group:		Space for Photo	M Er	nrollment w.e.f.: obile No. : nail: ndhaar No. :	Space for Signature
2.	Name of Beneficiary	Relation With Teacher/ Offi	Beneficiary ID : Relation With Teacher/ Officer: Date of Birth:		M En	arollment w.e.f.: obile No. : nail: adhaar No. :	Space for Signature
3.	Name of Beneficiary	Relation With Teacher/ Offi	Beneficiary ID : Relation With Teacher/ Officer: Date of Birth:		M Er	arollment w.e.f.: obile No. : nail: adhaar No. :	Space for Signature
4.	Name of Beneficiary	Beneficiary II Relation With Teacher/ Offi Date of Birth Blood Group	n cer: :	Space for Photo	M Er	arollment w.e.f.: obile No. : nail: adhaar No. :	Space for Signature
List	of Beneficiary witl	n Critical I	Diseases (If A	Any)			
	Beneficiary Name	Benef	ficiary ID Valid Upto			Certificate valid for Disease	

Certified that above mentioned Teacher/ Officer been enrolled under the WBHS for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health and Family Welfare, Govt. of West Bengal along with above mentioned family members to get medical treatment under the scheme.

Name (Block Letter):	
Designation:	

Space for Digital Signature Digitally Signed. Does not require any Ink Signature.

Reimbursement for cost of Out-Door Patient (OPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where Teacher/Officer is attached)

То

Tł	ne			(Designation	on o	f HoI)			
		(Name of the Institution)							
				(Office Ac	ldre	ess of Hol)			
Si	r/Madam	,							
	•	•	claim of Rs	(Rupees	S) towards	
re			f Out-Patient Depart						
			gal Health Scheme fo						
	•	_	lth & Family Welfare,	Govt. of W	est	Bengal as pe	_		
ı				General Info	rm	ation]			
		Details of Teach	ner/Officer.						
	Full Nam	_			Н	RMS ID (If a	vailable)		
	(in Block								
	Enrollme	ent ID No.				aim Applica			
						•	it the time of		
							from the end		
						f Head of Of	· · · · · · · · · · · · · · · · · · ·		
			nt, Treating Hospital	and Condo	nati	ion Require	ment, if any.		
	2.1	Name of Patie	ent						
	2.2	Name of Empa	anelled/Enlisted hosp	ital where					
		treatment wa							
	2.3	Requirement	of approval of delay (Condonatio	٦,	Yes □	No □ N	Not known 🗆	
		if any(Tick ma	rk in appropriate box)					
	3. [Details of Claim	ant (Applicable in cas	se of death	of e	mployee)			
	Sl. No.		Name of claimant	,			Relati	on	
	3.1								
	4. F	Permission Deta	ails, If any						
	Sl. No.	Permi	ission sought	De	tails	of permiss	ion approval		
	4.1	For treatmen	For treatment availed in enlisted				:		
		hospital out	side West Bengal	Date:					
		(see clause 1.	2 of Notification No.	Designation	n/	Authority:			
		Dated HF/	O/MERT/594/HFW-	U.O. No. a	nd (date of			
		24011(13)/2/	/2020 Dated:	Finance D	eptt	. West Beng	gal, if any:		
		Kolkata, the 2	21 st June, 2021)).						

Part-II [Details of Expenditure Statement of OPD treatment]

5.	Details o	of OPD Treatment	-							
SI. No.		Particulars					De	tails		
5.1	mark list	ory of OPD Claim (Ti in appropriate box)[So of diseases/illne oned in clause 6(1) an	ee OF	As per clause 6(1) of DPD List			As per cla of OPD Lis			
5.2	Name follow and tr	Name of OPD Disease/ Type of follow-up medical attendance and treatment					ı			
5.3		of OPD consultation								
	Expendi	ture Statement of OPD								
SI. No.		Nar	ne of C	Compone	nts				Amou Claimed	
6.1	Proced	ure Charges								
	Sl. No.	Name of Procedure	P	rocedure	Code	Amount Admissible (Rs)				
6.2	Consult	ation Fees								
6.3	Cost of	Pathological and Radio	logical	Investiga	tions					
	SI. No.	Name of Investigation		ded / Non- Code of Amount Coded Investigation Admissible (Rs)						
6.4	Cost of	Medicines								
	Period	of medicine consumption	on	From			То			
6.5	Cost of Implant / Special Device									
	SI. Name of Implant / Speci No. Device			al Code of Implant Amount / Special Device Admissible (Rs)						
6.6	Miscell	aneous (specify)		•						
								Total		
							No	of Vouchers		

Part-III [Medical Advance]

7. Details of Medical Advance, if any							
Name of Treasury from	DDO	Designation of	Treasury	Treasury	Amount		
where it was drawn	Code	DDO	Voucher No.	Voucher Date	(Rs.)		

Manual Application Form

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any							
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount		
where it was drawn	Code		Challan No.	Challan Date	(Rs.)		

Net Claim: [Part-II minus Part III] or [Part-II minus Part-III plus Part IV]						
Rs.:	In words: Rupees					

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Annexure-I duly signed with proper stamp by Treating Specialist of	Vas \square	No □
	an Empanelled/Enlisted Hospital (See notes of annexure-I carefully).	Yes □	No □
2	Enrolment Certificate of beneficiary	Yes □	No □
3	Original Money Receipts in sequentially	Yes □	No □
4	Copy of OPD Prescription	Yes □	No □
5	Copy of permission granted if any	Yes □	No □
6	Original copy of Voucher/ Tax Invoice of Implants purchased	Yes □	No □
7	Copy of all investigation/ test reports sequentially.	Yes □	No □
8	Essentiality supported with prescription and audiometric report		
	from treating empanelled hospital/diagnostic centre (Applicable	Yes □	No □
	only for claiming reimbursement of Digital Hearing Aid).		
9	In case of death of Teacher/Officer;		
	a. An, affidavit on stamp paper by claimant	Yes □	No □
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No □
	c. Copy of death certificate	Yes 🗆	No □
10	Filled ECS mandate form in case of those, whose bank details is not		
	available in IFMS (in case of first claim only)	Yes □	No□
11	Any other instruments (Specify)	Yes □	No □

	10	Filled ECS mandate form in case of those, whose bank details is not				
		available in IFMS (in case of first claim only)				
	11	Any other instruments (Specify)		Yes 🗆		
D	ate:					
_			Signature of the Teacher/Officer/Cla	imant :		
		,	Name in Block Letters:			
		1	Designation:			

Reimbursement for cost of Out-Door Patient (OPD) treatment in

recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

(Generated by Teacher/Officer from WBHS Portal)

To	0										
Tl	he	(Designation of Hol)									
					(Name	of the	Institution)				
					(Office	Addr	ess of Hol)				
Si	r/Madam,										
)
-		reimbursemer					•	•	•		at
	•	•		•		_				eficiaries of Grai	
		-	rsities un	ider Depa	rtment of H	ealth	& Family We	elfare, Govt	. of	West Bengal as p	er
d	etails state	ed below:		_			1				
	4 5		1000		t-I[General I	ntorm	<u>iation]</u>				
		etails of Teacl	ner/Offic	er.		Τ.	IDAAC ID /IC				
	Full Nam						IRMS ID (If a				-
		ent ID No.					Claim Applica Date of Enrol				-
	Bed Enti		Tuesd		tal and Can						
	2.1	Petails of Patie Name of Patie		ing Hosp	itai and Con	idona	tion Kequire	ment, if an	ıy.		
	2.1	Name of Patie	:nu								
		Beneficiary ID)								
		Relationship v	with Emp	loyee							
	2.2	Name of Emp	anelled/	Enlisted h	ospital whe	re					
		treatment wa	s availed	l.							
	-	Code of Hosp	ital								_
	-	Class of Entitl	ement o	f Hospital							
		Address of Ho	spital								
	2.3	Requirement	of appro	val of del	ay Condona	tion,	Yes □	No□	No	ot known□	
		if any(Tick ma		•	•						
	3. D	etail of Claima				h of e	mployee)				
	Sl.No.		Nam	e of claim	nant			Re	elatio	on	
	3.1										
											_
		ermission Det		-							
	Sl. No.		ission so		11 11			permission	n app	oroval	
	4.1	For treatmen			•		no No.			:	
		outside Wes	_	-	-	Date		Lla a		:	
		Notification/	-		/594/HFW-	-	gnation / Aut No. and date	-		:	
		24011(13)/2,		Dated:	Kolkata,				;f -	nnv:	
	I	the 21st June	, ZUZI).			Lillat	nce Deptt., V	vest peliga	1, 11 6	arry.	1

Part-II [Details of Expenditure Statement of OPD treatment]

5.	Details o	of OPD Treatment					<u>,</u>				
Sl. No.		Particulars		Details							
5.1	mark list	ory of OPD Claim in appropriate box of diseases/ oned in clause 6(1	(illness				As per clau	As per clause 6(2) of OPD List			
5.2											
5.3		of OPD consultation									
	Expendi	ture Statement of (
SI. No.			Name o	f Con	npon	ents				Amou Claimed	
6.1	Proced	ure Charges									
	Sl. No.	Name of Procedu	re Pro	ocedu	ıre C	ode	Amou	ınt Adr	nissible (Rs)		
6.2		ation Fees									
6.3		Pathological and Ra					1				
	Sl. No.	Name of Investigation	Coded , Non- Coded	/	Cod	e of estigati	on	Amou Admis	int ssible (Rs)		
6.4	Cost of	Medicines					I				
	Period (of medicine consum	nption	Fro	m			То			
6.5	Cost of Implant / Special Device										
	Sl. No.	Name of Implant ,		Cod	le of	Implar	nt /	Amou	int		
		Special Device		Special Device Admissible (Rs)							
6.6	Miscell	aneous (specify)		<u> </u>							
									Total		
	No. of vouchers										

Part-III [Medical Advance]

7. Details of Medical Advance, if any										
Name of Treasury from	DDO	Designation of	Treasury	Treasury	Amount					
where it was drawn	Code	DDO	Voucher No.	Voucher Date	(Rs.)					

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any										
Name of Treasury from DDO Designation of DDO Treasury Treasury Am										
where it was drawn	Code	Challan No.	Challan Date	(Rs.)						

Online Application Form

Net Claim: [Part-II minus Part III] or [Part-II minus Part-III plus Part IV]					
Rs. ;	In words; Rupees				

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Annexure-I duly signed with proper stamp by Treating Specialist of an Empanelled/Enlisted Hospital (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 granted if any	Yes □	No □
5	Original copy of Voucher/ Tax Invoice of Implants purchased	Yes □	No □
6	Copy of all investigation/ test reports sequentially.	Yes □	No □
7	Essentiality supported with prescription and audiometric report from treating empanelled hospital/diagnostic centre (Applicable only for claiming reimbursement of Digital Hearing Aid).	Yes □	No □
8	In case of death of Teacher/Officer;		
	a. An, affidavit on stamp paper by claimant	Yes □	No □
	b. No objection from other legal heirs on stamp papers	Yes 🗆	No □
	c. Copy of death certificate	Yes □	No □
9	Any other instruments (Specify)	Yes □	No □

Date:		
Date.	Signature of the Teacher/Officer/Claimant	:
	Name in Block Letters:	
	Designation:	

Reimbursement for cost of In-Patient Department (IPD) treatment in non-empanelled hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021) (Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where Teacher/Officer is attached)

			(Designation of (Name of the I (Office Addre	nstitutio	•		
towards r Bengal He	am submitting a creimbursement of costealth Scheme for the E	t of In-P Beneficia	atient Department (IP	D) treati lleges a w:	ment at non-empanelled nd Universities under De on]	hospital under West	
1.	Details of Teacher,	/Officer	·.				
Full N				HRMS	S ID (If available)		
(in Blo	ock letters)						
Enrollment ID No.				(To be	Application ID e filled at the time of e entry from end the of Office)		
2.	Detail of Patient, T	reating	Hospital and Condo		· · · ·		
2.1	Name of Patient		•		, ,		
2.2	Name of Non-Empa	anelled,	/hospital where treat	ment			
2.3	Requirement of ap Any(Tick mark in a	•	of delay Condonation ate box)	, if	Yes □ No □	[]] Not known □	
3.	Detail of Claimant	(Applica	able in case of death	of empl	loyee)		
Sl. No).	Name (of claimant	Relation			
3.1							
	<u>Part-II</u>	[Detail	s and Expenditure St	atemer	nt of IPD treatment]		
4.	Period of treatment	;					
Admis	ssion Date			Discha	arge Date		
5.	Type of Discharge						
Sl. No. Type of Discharge Tick mark in appropriate box		Sl. No.	Type of Discharge	Tick mark in appropriate box			
5.1 Normal			5.3	Referral			
5.2	Risk Bond			5.4	Death		
6.	Amount Claimed for	r					
SI. No			Type of Treatme	ent		Tick mark in appropriate box	
6.1	Only Procedural	/ Packa	ge Treatment				

Manual Application Form

6.2	Only Non- Procedural/ Package Treatment							
6.3	Both Procedural/ Package and No	eatment						
6.1 Det								
Period of	Procedural/ Package Treatment		Fro	om		То		
Sl. No	Name of Pro	cedures/	Package:	S		Amo	unt Claimed	
							(Rs.)	
6.1.1								
6.1.2								
6.1.3								
6.1.4								
6.1.5								
					Total			
6.2 Det	ails of Implants Used							
Sl. No.	Name	of Impla	ints			Amo	unt Claimed	
							(Rs.)	
6.2.1								
6.2.2								
6.2.3								
6.2.4								
					Total			
6.3 Deta	ils of Non-Procedural/ Package Tre	eatment						
Period of	Non-Procedural/Package Treatm	ent		From		To		
Sl. No.	Name o	f Compo	nents			Amo	unt Claimed	
							(Rs.)	
6.3.1	Room/ Bed Rent	1	T		,			
	ICCU/ITU/ICU/NICU/PICU	From		То				
	HDU/SDU	From		То				
	Burn Unit	From		То				
	CRIB	From		То				
	General/Semi-Private/Private	From		То				
6.3.2	Consultation Fees							
6.3.3	Pathological and Radiological Inve	stigation	ıs					
6.3.4	Medicines							
6.3.5	Consumables							
6.3.6	Special Nursing/Aya Charges							
6.3.7	Miscellaneous. (If Any Specify)							
					Total			
					o. of Vouchers			
		Tota	l Treatme	ent Cost	[6.1+ 6.2+6.3]			

Part-III [Details of Discount and Insurance Coverage]

11. Details of Discount and Insurance Coverage, if any									
Sl. No.	Particulars	Amount (Rs.)	Remarks						
1	Discount								
2	Insurance Coverage								

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Manual Application Form

No □

No □

Net Claim:(Part-II minus Part-III)				
Rs. ;	In words; Rupees			

Part-IV [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures] SI. Name/Particulars of enclosures to be attached Enclosed or not No. Annexure-II duly signed with proper stamp by the Medical Yes □ No □ 1 Superintendent / Administrative Officer of a Non-Empanelled Hospital **Enrolment Certificate of beneficiary** No□ 2 Yes 🗆 No □ 3 **Bill Summary** Yes □ 4 Original Money Receipts in chronological dates Yes □ No □ 5 Copy of Discharge Summary (case summary and copy of death Yes □ No □ certificate in case of death) and OT note Yes □ 6 **Detailed Bill** No □ 7 Original copy of Voucher/ Tax Invoice of Implants used Yes □ No □ Copy of all investigation/ test reports sequentially Yes □ No □ 8 Copy of OT Note in case of procedural/package treatment and 9 Yes □ No □ treatment summary or bed head ticket in case of nonprocedural/package treatment In case of death of Teacher/Officer; 10 a. An affidavit on stamp paper by claimant Yes □ No □ b. No objection from other legal heirs on stamp papers Yes □ No □ No □ 'es □

		c. Copy of death certificate	Yes □					
	11	Filled ECS mandate form in case of those, whose bank details is not						
		available in IFMS (in case of first claim only)						
	12	Any other instruments (Specify)						
Da	ate:	Signature of the Teacher/Officer/Claim Name in Block Letters: Designation:	ant:					

Reimbursement for cost of In-Patient Department (IPD) treatment in non-empanelled hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

		(Gener	ated by Teacher/Offic	er from	WBHS Port	al)		
То			-					
The			(Designation o	f Hol)				
			(Name of the					
			(Office Addre	ss of Hol	1)			
Sir/Mada	am.							
=	•	claim of	Rs (Rupe	Δς.				1
			Patient Department (IF					-
			aries of Grant-in-Aid Co					
			s per details stated belo					
,	,	Ü	Part-I[General In		on]			
1.	. Details of Teach	er/Office	r.					
Full N	lame			HRMS	S ID (If availa	able)		
Enrol	lment ID No.			Claim	Application	ID		
Bed E	Entitlement			Date	of Enrolmen	it		
2.	. Details of Patier	nt, Treatin	ng Hospital and Cond	onation	Requireme	nt, if any		
2.1	Name of Patient	•						
	Beneficiary ID							
	Relationship wit	h Teacher	/Officer					
2.2	Name of Non-Er	npanelled	/hospital where trea	tment				
	was availed.	-	•					
	Bed Capacity of	Hospital						
	CE Licence No.	-						
	CE Licence valid	up to						
	Address of Hosp	ital						
2.3	Requirement of	approval	of delay Condonatior	ı, if	Yes □	No 🗆	Not known	
	any (Tick mark in		•					
3.	. Details of Claim	ant (Appli	cable in case of deatl	h of emp	oloyee)			
SI.No	D.	Name	of claimant			Relati	on	
3.1	l							
	•			•				
	Pa	rt-II [Deta	ils of Expenditure Sta	atement	t of IPD trea	tment]		
4.	Period of treatn	nent						
Admi	ssion Date			Discha	rge date			
5.	. Type of Dischar	ge						
SI. N	o. Type of Disc	charge	Tick mark in	Sl. No.	Type of	Discharge	Tick ma	rk in
			appropriate box				appropria	te box
5.1	Normal			5.3	Referral			
5.2	Risk Bond			5.4	Death			
6.	. Amount Claime	d for						
SI. N	о.		Type of Treatm	ent			Tick ma	rk in
							appropria	te box
6.1	Only Procedu	ral/ Packa	ige Treatment					

Online Application Form

6.2	Only Non- Procedural/ Package Tr						
6.3	Both Procedural/ Package and Nor						
6.1 C	Details of Procedural/ Package Trea						
	eriod of Procedural/ Package Trea		Fr	om			То
Sl. No	Name of Pro		' Package	es			Amount Claimed
		·	J				(Rs.)
6.1.1							
6.1.2							
6.1.3							
6.1.4							
6.1.5							
						Total	
6.2 C	Details of Implants Used						
Sl. No.	Name	of Impla	nts				Amount Claimed
							(Rs.)
6.2.1							
6.2.2							
6.2.3							
6.2.4							
						Total	
6.3 D	etails of Non-Procedural/ Package	Treatme	ent				
	Non-Procedural/ Package Treatm			Fro	m		То
Sl. No.	Name of	f Compoi	nents				Amount Claimed
							(Rs.)
6.3.1	Room/ Bed Rent					1	
	ICCU/ITU/ICU/NICU/PICU	From			То		
	HDU/SDU	From			То		
	Burn Unit	From			То		
	CRIB	From			То		
	General/Semi-Private/Private	From			То		
6.3.2	Consultation Fees						
6.3.3	Pathological and Radiological Inve	stigation	IS				
6.3.4	Medicines						
6.3.5	Consumables						
6.3.6	Special Nursing/Aya Charges						
6.3.7	Miscellaneous. (If Any Specify)						
						Total	
					A.,	6) / !	
					No	o. of Vouchers	
		Toto	l Trooting	ont f	Cost	[6.1, 6.2, 6.2]	
Total Treatment Cost [6.1+ 6.2+6.3]							

Part-III [Details of Discount and Insurance Coverage]

11. Details of Discount and Insurance Coverage, if any								
Sl. No.	Particulars	Amount (Rs.)	Remarks					
1	Discount							
2 Insurance Coverage								

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Online Application Form

Net Claim:(Part-II minus Part-III)					
Rs.;	In words; Rupees				

Part-IV [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

[=:000	i Enclosures _j		
SI.	Name/Particulars of enclosures to be attached	Enclosed or not	
No.			
1	Annexure-II duly signed with proper stamp by the Medical		
	Superintendent / Administrative Officer of a Non-Empanelled Hospital	Yes □	No □
2	Bill Summary	Yes □	No □
3	Original Money Receipts in chronological dates	Yes □	No □
4	Copy of Discharge Summary (case summary and copy of death		
	certificate in case of death) and OT note	Yes □	No □
5	Detailed Bill	Yes □	No □
6	Original copy of Voucher/ Tax Invoice of Implants used	Yes □	No □
7	Copy of all investigation/ test reports sequentially	Yes □	No □
8	Copy of OT Note in case of procedural/package treatment and		
	treatment summary or bed head ticket in case of non-procedural/package treatment	Yes 🗆	No 🗆
9	In case of death of Teacher/Officer;		
	a. An affidavit on stamp paper by claimant	Yes □	No □
	b. No objection from other legal heirs on stamp papers	Yes □	No □
	c. Copy of death certificate	Yes □	No □
10	Any other instruments (Specify)	Yes □	No □

D	ate:		
		Signature of the Teacher/Officer/Claima	nt :
		Name in Block Letters:	
		Designation:	

Reimbursement for cost of In-Patient Department (IPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where Teacher/Officer is attached)

To									
Th	e		(Designat	of HoI)					
			(Name o		•				
	(Office Address of HoI)								
Sir	/Madan			15				,	
٠.			g a claim of Rs nt of cost of non-casi						
	wards	reimburseme				-	ment (IPD)		
	_	•	enlisted hospital under West B s under Department of Health &	_					
	low:	ila Olliversities	didei Department of Hearth &	k i aiii	illy vvellale,	GOVE. OF V	rest beligal as	per details stated	
	1000		Part-I[Gener	ral In	formationl				
	1. De	etails of Teacl		<u> </u>					
	Full Na					HRMS ID	(If		
	(in Block					available	•		
	Enrollr	nent ID No.					plication ID.		
						(To be filled	at the time of		
						online entry Head of Off	from the end of		
	2. De	etails of Patie	nt, Treating Hospital and Cor	ndon	ation Requi				
	2.1	Name of Pati	•		actor noqui		,		
	2.2		panelled/Enlisted hospital						
			nent was availed						
	2.3		of approval of delay	Ye	es 🗆	No	□ Not K	(nown \square	
		•	, if any (Tick mark in		-				
		appropriate l	• •						
	L		,					-	
	3. De	etails of Claim	nant (applicable in case of dec	ath o	f employee)				
	Sl. No.		Name of claimar		. , ,		Re	lation	
	3.1								
	4. Pe	ermission Det	ails (If any)						
	Sl. No.	Per	mission sought		Details of permission approval				
	4.1	For treat	ment availed in empane	lled	Permission	n ID	:		
			ospital within West Bengal		Permission	n approve	d for:		
	clause 14 of Order No. 796 and 797, dated								
	31.01.2011, 11253-F(MED), dated; 16.12.2011 and 7578-F(MED) dated;04.09.2012]								
	4.2		nent availed in enlisted hosp	nital	Memo No			•	
	4.2		lest Bengal (see clause 12		Date:	•		•	
			n No. HF/O/MERT/594/HI	•	Date. Designation	n / Autho	rity :		
			/2/2020 Dated: Kolkata, the		U.O. No. a		•		
		June, 2021		_					
		Julie, 2021	1		Finance Deptt. West Bengal, if any:				

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Reimbursement Mode											
Period o	Period of treatment Admission Date Discharge date										
6. Тур	. Type of Discharge										
Sl. No.	Type of Di	scharge	(Tick ma	rk in	SI. N	No.	Type of	Discha	rge	rge (Tick mark in	
			appropriat	te box)						appr	opriate box)
6.1	Norm	nal			6.	3	R	eferral			
6.2	Risk B	ond			6.	4	I	Death			
7.Amou	nt Claimed for	r									
Sl. No.			Type of Tr	eatmen	t					(Tic	k mark in
										appro	priate box)
7.1	Only Procedu	ıral/ Packag	e Treatmen	t							
7.2	Only Non- Pr	ocedural/ N	lon-Package	Treatm	ent						
7.3	Both Procedu	ural/ Packag	ge and Non-	Procedu	ıral/ I	Non-	Package	!			
	Treatment										
7.1 De	tails of Proced	dural/ Packa	age Treatme	ent							
Pe	riod of Proced	lural/ Packa	ige Treatme	ent	Fr	om				То	
Sl. No.	Na	ame of Proc	edures/ Pac	kages				edure ode	А	mount	Claimed(Rs.)
7.1.1							CC	ue			
7.1.2											
7.1.3											
7.1.4											
7.1.5											
712.0								Tota	ı		
7.2 De	etails of Impla	nts Used							<u> </u>		
Sl.No.	•	e of Implan	ts	Coded	or No	on-	Impla	ints	An	nount C	aimed (Rs.)
		·		coded			Code, if				
							cod	ed			
7.2.1											
7.2.2											
7.2.3											
7.2.4											
7.2.5											
							Tota	(Rs.)			
	tails of Non-P				ment			I			
	of Non-Proced	ural/ Non-F					From			То	L
Sl. No.			Name of Co	ompone	nt					Amou	int Claimed (Rs.)
7.3.1	Room/ Bed Rent								•		
	ICCU/ITU/ICU/NICU/PICU From					То					
	HDU/SDU From					То					
	Burn Unit F		Fror	n		То					
	CRIB From			То							
	General/Sem	ni-Private/Pr	rivate	Fror			То				
7.3.2	Consultation				ı						
7.3.3	Pathological	and Radiolo	gical Invest	igations.							
7.3.4	Medicines.										

7.3.5	Consumables						
7.3.6	Special Nursing/Aya Charges						
7.3.7	Miscellaneous. (If any specify)						
	Total Claim of Reimbursement Mode of Treatment(Rs.)						
	(amount mentioned in 7.1+ 7.2+7.3)						

Part-III [Details of Expenditure Statement of Indoor related OPD treatment]

	Part-III [Details of Expenditure Staten	<u>ient of i</u>	<u>ndoor relat</u>	ea or	<u>v treatment</u>	<u>[</u>				
8. In	door related OPD treatment									
tr pr	o you want to claim Indoor related eatment cost i.e. cost of OPD treatment is rior to admission and 30 days after disc ick mark in appropriate box)	30 days	Yes □			No□				
9. De										
	Dates		N	os. of	Consultation					
10. D	etails Expenditure of Indoor related OPD t	reatmen	nt							
SI.	Name of Com	ponents				Amount				
No.						Claimed (Rs.)				
10.1	Consultation Fees									
10.2	Cost of Pathological and Radiological Inves	stigation	S							
10.3	Cost of Medicines									
	Period of medicine consumption	From		То						
10.4	Cost of Special Device									
10.5	Miscellaneous (specify)									
	٦	Total clai	m of indoor	relate	ed OPD(Rs.)					
				Nos.	of vouchers					

Part-IV [Medical Advance]

11. Details of Medical Advance, if any									
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount				
where it was drawn	Code		Voucher No.	Voucher Date	(Rs.)				

Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any								
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount			
where it was drawn	Code		Challan No.	Challan Date	(Rs.)			

Part-VI [Details of Discount and Insurance Coverage]

13. Detai	13. Details of Discount and Insurance Coverage, if any								
Sl. No.	Particulars	Amount (Rs.)	Remarks						
1	Discount								
2 Insurance Coverage									

Net Claim: [Part-II plus Part-III minus Part IV minus Part VI] or [Part-II plus Part-III minus Part IV plus Part V minus Part VI]							
Rs.;	In words; Rupees						

Part-VII [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Triacoi	Liiciosuresj			
Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not		
1	Enrolment Certificate of beneficiary	Yes □	No □	
2	Bill Summary of Indoor Treatment and OPD treatment	Yes □	No □	
3	Original Money Receipts of both Indoor and OPD treatment in			
	chronological dates	Yes □	No □	
4	Copy of related OPD Prescriptions (if claimed)	Yes □	No□	
5	Copy of Discharge Summary (case summary and copy of death			
	certificate in case of death) and OT note	Yes□	No □	
5	Copy of permission granted, if any	Yes □	No□	
7	Copy of compliance of clause (3) or (4) or (5) as per Memo No.			
	11253(80) F (MED), dated 16/12/2011, if any	Yes □	No□	
8	Copy of Detailed Bill of Indoor Treatment	Yes □	No □	
9	Original copy of Voucher/ Tax Invoice of Implants used	Yes □	No □	
10	Copy of all investigations/ tests report of Indoor and Indoor related			
	OPD treatment sequentially	Yes □	No □	
11	In case of death of Teacher/Officer;			
	a. An, affidavit on stamp paper by claimant	Yes □ Yes □	No □ No □	
	b. No objection from other legal heirs on stamp papers	Yes □	No □	
	c. Copy of death certificate	163 🗖	100 🗖	
12	Filled ECS mandate form in case of those, whose bank details is not			
	available in IFMS (in case of first claim only)	Yes □	No □	
13	Any other instruments (Specify)	Yes □	No □	

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ı	J	а	ι	C	•

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Reimbursement for cost of In-Patient Department (IPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

(Generated by Teacher/Officer from WBHS Portal)

	ne		(Designa (Name (Office	of the In	stitution)				
to re Cc	wards cognise	am submitti reimbursem ed/empanelled	ing a claim of Rs nent for cost of non-ca l/enlisted hospital under West es under Department of Health	shless Bengal	In-Patie Health Sc	nt Depart heme for th	ment (IPD) ne Beneficiario	treatment at es of Grant-in-Aic	ł
ı			Part-I[Gene	eral Info	rmation]				1
	1. D	etails of Tea	cher/Officer.						
	Full N	lame				HRMS ID (lf		
						available)			
	_	lment ID				Claim App	lication ID.		
	No.					Date of En			ļ
		ntitlement							l
		T .	ent, Treating Hospital and Co	ndonat	ion Requ	urement, if	any		ļ
	2.1	Name of Pa							
		Beneficiary							
			o with Teacher/Officer						
	2.2		npanelled/Enlisted hospital						
			ment was availed.						
		Code of Hos	•						
		Class of Ent	itlement of Hospital						
		Address of	•						
	2.3	Requiremen	nt of approval of delay	Yes [No	□ Not K	(nown \square	
		Condonatio	n, if any (Tick mark in						
		appropriate	e box)						L
	3. D	etails of Clai	mant (applicable in case of de	ath of e	employee	e)			
	SI. No).	Name of claima	nt			Re	elation	
	3.1								
	4. P	Permission De	etails (If any)						
	Sl. No). Pe	ermission sought			Details of	permission a	pproval	
	4.1		ment availed in empanelled p		Permiss	ion ID	:		
		hospital	within West Bengal [<i>see clau</i>	ise 14	Permiss	ion approv	ed for:		
		of Order	No. 796 and 797, dated 31.01.	2011,					
		11253-F(MED), dated; 16.12.2011 and	7578-					
		F(MED) d	ated;04.09.2012]						

4.2	For treatment availed in enlisted hospital	Memo No. :
	outside West Bengal (see clause 12	Date :
	of Notification No. HF/O/MERT/594/HFW-	Designation / Authority :
	24011(13)/2/2020 Dated: Kolkata, the 21st	U.O. No. and date of
	June, 2021)	Finance Deptt. West Bengal, if any:

	Part-II [Deta	ils of Expendi	iture St	aten	nent	of IP	D tre	eatmer	<u>nt]</u>			
5. Det	ails of Treatment in Reim	bursement N	Vlode									
Period o	of treatment Admi	ssion Date				D	ischa	irge da	te			
6. Тур	e of Discharge											
Sl. No.	Type of Discharge	(Tick mar	k in	SI. I	No.	Тур	e of	Discha	rge	(Tic	k mark in	
		appropriate	e box)							appro	opriate box))
6.1	Normal			6	.3		Ref	erral				
6.2	Risk Bond			6	.4		De	eath				
7. Am	nount Claimed for											
Sl. No.		Type of Tre	eatmen	t						(Ticl	k mark in	
										appro	priate box)	
7.1	Only Procedural/ Packag	e Treatment										
7.2	Only Non- Procedural/ N	Ion-Package ⁻	Treatm	ent								
7.3	Both Procedural/ Packag	ge and Non- P	rocedu	ıral/	Non-	Pack	age					
	Treatment											
7.1 De	tails of Procedural/ Pack	age Treatmei	nt									
Pe	riod of Procedural/ Packa	age Treatmer	nt	Fı	rom					То		
Sl. No.	Name of Proc	edures/ Pack	ages			Р	roce	dure	Α	mount (Claimed(Rs.)
							Cod	de				
7.1.1												
7.1.2												
7.1.3												
7.1.4												
7.1.5												
								Total				
7.2 De	etails of Implants Used											
Sl. No.	Name of Implan	ts	Coded	or N	on-	In	nplar	nts	An	nount Cl	aimed (Rs.)	
			CO	ded		C	Code,	if				
						(code	d				
7.2.1												
7.2.2												
7.2.3												
7.2.4												
7.2.5												
						Т	otal	(Rs.)				
7.3 De	tails of Non-Procedural/	Non-Package	Treatr	ment	t.							
Per	riod of Non-Procedural/ N	Non-Package	Treatn	nent.		Fro	m			То		
Sl. No.		Name of Cor	nponer	nts						Amou	nt Claimed (Rs.)	
7.3.1	Room/ Bed Rent										. ,	
	ICCU/ITU/ICU/NICU/PIC	U	Fror	n			То					
	HDU/SDU		Fror	n			То					

	Burn Unit	From	То				
	CRIB	From	То				
	General/Semi-Private/Private	From	То				
7.3.2	Consultation Fees.						
7.3.3	Pathological and Radiological Invest						
7.3.4	Medicines.						
7.3.5	Consumables						
7.3.6	Special Nursing/Aya Charges						
7.3.7	Miscellaneous. (If any specify)						
	Total Claim of Reim	bursement Mod	le of Treatment(Rs.)			
		(amount mentio	ned in 7.1+ 7.2+	7.3)			
	No. of vouchers						

	Part-III [Details of Expenditure Staten	<u>nent of Ir</u>	ndoor rela	<u>ted OF</u>	<u>PD treatment</u>	
8. In	door related OPD treatment					
tre pri	you want to claim Indoor related eatment cost i.e. cost of OPD treatment s ior to admission and 30 days after disc ck mark in appropriate box)	30 days	Yes [No 🗆
9. Det	tails of Indoor related OPD Consultation					
	Dates		N	los. of	Consultation	
10. D	etails Expenditure of Indoor related OPD t					
Sl. No.	Name of Con	ponents	;			Amount
						Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Inve	stigation	ıs			
10.3	Cost of Medicines					
	Period of medicine consumption	From		То		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	7	otal clai	m of indoo	r relat	ed OPD(Rs.)	
				Nos.	of vouchers	

Part-IV [Medical Advance]

11. Details of Medical Advance, if any									
DDO	Designation of DDO	Treasury	Treasury	Amount					
Code		Voucher No.	Voucher Date	(Rs.)					
	DDO	DDO Designation of DDO	DDO Designation of DDO Treasury	DDO Designation of DDO Treasury Treasury					

Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any									
Name of Treasury from	DDO	Designation of DDO	Treasury	Treasury	Amount				
where it was drawn	Code		Challan No.	Challan Date	(Rs.)				

Part-VI [Details of Discount and Insurance Coverage]

13. Details of Discount and Insurance Coverage, if any								
Sl. No.	Particulars	Amount (Rs.)	Remarks					
1	Discount							
2	Insurance Coverage							

Net Claim: [Part-II plus Part-III minus Part IV minus Part VI] or [Part-II plus Part-III minus Part IV plus Part V minus Part VI]						
Rs. ;	In words; Rupees					

Part-VII [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Bill Summary of Indoor Treatment and OPD treatment sequentially	Yes □	No □
2	Money Receipts of both Indoor and OPD treatment sequentially	Yes □	No □
3	Original Money Receipts of both Indoor and OPD treatment in chronological dates	Yes □	No □
4	Copy of Discharge Summary (case summary and copy of death certificate in case of death) and OT note	Yes□	No □
5	Copy of permission granted if any.	Yes □	No□
6	Copy of compliance of clause (3) or (4) or (5) as per Memo No.		
	11253(80) F (MED), dated 16/12/2011, if any	Yes □	No□
7	Copy of Detailed Bill of Indoor Treatment	Yes □	No □
8	Original copy of Voucher/ Tax Invoice of Implants used	Yes □	No □
9	Copy of all investigations/ tests report of Indoor and Indoor related	Yes □	No □
	OPD treatment in sequence manner (In chronological order)		
10	In case of death of Teacher/Officer;		
	a. An affidavit on stamp paper by claimant	Yes	No 🗆
	b. No objection from other legal heirs on stamp papers	Yes □ Yes □	No □ No □
	c. Copy of death certificate	res 🗆	INO L
11	Any other instruments (Specify)	Yes □	No □

Date:

Signature of the Teacher/Officer/Claimant : Name in Block Letters:

Designation:

Out-Patient Department (OPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme Hospital for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021) (Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where Teacher/Officer is attached)

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					(Designatio	n of H	lol)				
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						Office Ad	dress	of H	lol)			
Si	r/Madam	•										
)
						-	•			_		npanelled/enlisted
	•	_									_	es and Universities
J٢	ider Depa	artment of Heal	th & Family					_	as p	er details s	tate	d below:
			/a.ss:	<u>Pa</u>	rt-I[Gei	neral Info	rmati	<u>on</u>]				
		Details of Teach	ier/Otticer.					46.15	/ . c		T	
	Full Nam	_					HRIV	/IS IL) (I† a	available)		
		(letters)					Clair		منامد	ation ID.		
	Enrollme	ent ID No.							•	ation ib. at the time	of	
							-	-		from the e	-	
									-	-	,,,,	
of Head of Office) 2. Details of Patient, Treating Hospital.												
	2.1	Name of Patie										
	2.2	Name of Empa			hospita	al from						
		where estimat	te is receive	d.								
			Part-II [Deta	ils of Co	ost Compo	onent	t of E	stin	natel		
	3. Es	timate of Hosp				-						
	3.1 No	o. of days for w	hich hospit	al pr	oduced	t						
	Es	stimated Expen	diture							() Da	iys	
	3.2	Details of OPD	Diseases fo	r wl	nich adv	vance is so	ought	ţ				
	Sl. No.	Particu						Nam	ne of	diseases		
	3.2.1	Name of OP	D Diseases									Carcinoma
		for which a			BetaT	hallsaemia	3		He	epatitis C	Ш	including
		required(Tick										Multiple
		appropriate b	•			_						Myelomas
		Cost Componen	it of OPD tr	eatm	ent as	per estim	ate s	ubm	itte	d by Empan	ellec	d/Enlisted
hospital					T	T						
	SI.	Name o	of Compone	nt		Nos.					Amount (Rs.)	
	No.	Carrach 11 5					From To			To		
		Consultation Fe		11								
	4.2	Cost of Patholo	ogical and Ra	aaiol	ogicai	1	1			Ī		1

Manual Advance Application Form

	Investigations			
4.3	Cost of Medicines			
4.4	Cost of Implant / Special Device			
4.5	Miscellaneous (specify)			

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance (80 % of total of sl. no. 4)	
2	Amount of Advance Applied for	

Amount of Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III]						
Rs:						
In words:	Rupees					

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation		
1				

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

[LISC OI L	inclosures]			
Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not		
1	Enrolment Certificate of patient	Yes □	No □	
2	Original Estimate issued by Empanelled/Enlisted hospital for seeking advance	Yes □	No 🗆	
3	Prognosis Report of patient issued by Treating Specialist	Yes □	No □	
4	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only)	Yes□	No □	
5	Any other instruments (Specify)	Yes □	No□	

Date:		
Date.	Signature of the Teacher/Officer/Claimant :	
	Name in Block Letters:	
	Designation:	

Out-Patient Department (OPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme Hospital for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

(Generated by Teacher/Officer from WBHS Portal)

Го									
Гhe	(Designation of HoI)								
				•		•			
				. (Office Add	ress of	Hol)			
Sir/Madar	•			-					,
	am submitting a p	•							•
			•	-	-		-		lled/enlisted hospital es under Department
	& Family Welfare,						-	21 31 (16	es unuer Department
or ricultin	a ranning wentere,	dove. or west		·			v.		
1.	Details of Teacl	her/Officer.	Part	-I[General I	ntorm	<u>ation]</u>			
Full Na					Тн	RMS ID	(If available)		
	ment ID No.						olication ID.		
	ntitlement						nrolment		
	Details of Patie	nt. Treating I	lospi	ital					
2.1	Name of Patie		•						
	Beneficiary ID								
	Relationship v	with Teacher	'Offic	er					
2.2	Name of Emp	anelled/Enlis	ted h	ospital whe	re				
	treatment is a			ospital Wile					
	Code of Hospi								
	Class of Entitl	oment of He	اد+نما						
	Class of Entitle	ement of nos	pitai						
	Address of Ho	spital							
		Part-II [D	etail	s of Cost Co	mpon	ent of Es	stimatel		
3.	Estimate of Hos		-				<u></u>		
3.1	No. of days for	which hospi	tal pr	oduced					
	Estimated Expe	nditure					() Days		
3.2	Details of OPD	Diseases for	whic	h advance is	s sougl	ht			
SI. No	o. Partic	ulars				Name	of diseases		_
3.2.1	Name of OF	D Diseases							Carcinoma
	for which			Beta Thall	lsaemi	a 🗆	Hepatitis C		including
	required (Tick mark in								Multiple
	appropriate b	•							Myelomas
4.	Cost Componer	nt of OPD tre	atme	nt as per Es	timate	e submit	tted by Empar	elle	d/Enlisted
	hospital					T			
SI.	Nar	ne of Compo	nent		Nos.		Period		Amount (Rs.)
No.						Fro	m To		

Online Advance Application Form 4.1 **Consultation Fees** 4.2 Cost of Pathological and Radiological Investigations 4.3 Cost of Medicines 4.4 Cost of Implant / Special Device 4.5 Miscellaneous (specify) Total Part-III [Advance Amount Selection Clause] SI. No. **Particulars** Amount (Rs.) Maximum admissible amount for Advance (80 % of total of sl. no. 4) 1 2 Amount of Advance Applied for Amount of Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III] Rs: In words: Rupees Part-IV [Details of Advance Claimant] Name of Claimant SI. No. Relation 1 Part-V [Declaration of Teacher/Officer] I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner. [List of Enclosures] Sl. No. Name/Particulars of enclosures to be attached Enclosed or not Original Estimate issued by empanelled hospital for seeking advance 1 Yes 🗆 No □ No □ 2 Prognosis Report of patient issued by Treating Specialist Yes □ 3 Any other instruments (Specify) Yes□ No □ Date: Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

In-Patient Department (IPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021) (Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Institution where Teacher/Officer is attached)

0					
he			Designation of Ho	ol)	
				•	
			(Office Address o	of Hol)	
ir/Mada	ım,				
l a	am submittin	g a prayer of Rs	(Rupees		
		cost of In-Patient Depart		_	-
•		Bengal Health Scheme for			_
nder De	partment of	Health & Family Welfare, (Govt. of West Ben	gal as per detail	s stated below:
		D+ 1[C-		1	
1 0	ataila of Taga		eneral Informatio	<u>nj</u>	
	etails of Teac	ner/Officer.		LIDNAS ID (If	
Full Na	k letters)			HRMS ID (If	
	ment ID No.			available) Claim Applic	ation ID
Enroili	ment ib No.			(To be filled at th	
				online entry fron	
2 5	-1-" (D-1"-			Head of Office)	
		ent, Treating Hospital			
2.1	Name of Pat				
2.2		panelled/Enlisted hospital			
	wnere treati	ment availed			
		Dort II [Dotoils of /	Sact Commonant	of Estimatal	
2 Ecti	mate of Hosp	Part-II [Details of (cost Component	oi estimatej	
	•	or which hospital produce	nd Estimated Eve	ndituro	
3.1	ivo. Oi days i	or willer hospital produce	eu Estimateu Expe		() days
3.2	Estimate cost	t of Procedural/ Package 1	Treatment		() uays
Sl. No		Name of Procedures/ Pac		Procedure	Amount (Rs.)
31. 140	•	rame of Frocedures, Fac	Ruges	Code	7 tilloulle (113.)
3.2.1				Couc	
3.2.2					
3.2.3					
3.2.4					
3.2.5	1				
5.2.3				Tota	
3.3 E	Estimate cost	of Implants Used		. 3 tu	
SI. No		ame of Implants	Coded or Non-	Implants	Amount (Rs.)
		e fe succes	coded	Code, if	
				codod	

			Total	(Rs.)			
imate cost of Non-Procedural/ Non-	Package Treat	tmer	nt.				
Name of C	omponent					Amount (Rs.)	
Room/ Bed Rent							
ICCU/ITU/ICU/NICU/PICU	From		То				
HDU/SDU	From		То				
Burn Unit	From		То				
CRIB	From		То				
General/Semi-Private/Private	From		То				
Consultation Fees.							
Pathological and Radiological Invest	igations.						
Medicines.							
Consumables							
Special Nursing/Aya Charges							
Miscellaneous. (If any specify)	·		·				
Amount of Total E	stimate subm	ittec	by Hos	pital(I	Rs.)		
	amount menti	(amount mentioned in 3.2+ 3.3+3.4)					
	Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU HDU/SDU Burn Unit CRIB General/Semi-Private/Private Consultation Fees. Pathological and Radiological Invest Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify) Amount of Total E	Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU From HDU/SDU From Burn Unit From CRIB From General/Semi-Private/Private From Consultation Fees. Pathological and Radiological Investigations. Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify) Amount of Total Estimate subm	Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU From HDU/SDU From Burn Unit From CRIB From General/Semi-Private/Private From Consultation Fees. Pathological and Radiological Investigations. Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify) Amount of Total Estimate submittee	imate cost of Non-Procedural/ Non-Package Treatment. Name of Component Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU From To HDU/SDU From To Burn Unit From To CRIB From To General/Semi-Private/Private From To Consultation Fees. Pathological and Radiological Investigations. Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify) Amount of Total Estimate submitted by Hos	Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU From To HDU/SDU From To Burn Unit From To CRIB From To General/Semi-Private/Private From To Consultation Fees. Pathological and Radiological Investigations. Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify) Amount of Total Estimate submitted by Hospital(I	imate cost of Non-Procedural/ Non-Package Treatment. Name of Component Room/ Bed Rent ICCU/ITU/ICU/NICU/PICU From To HDU/SDU From To Burn Unit From To CRIB From To General/Semi-Private/Private From To Consultation Fees. Pathological and Radiological Investigations. Medicines. Consumables Special Nursing/Aya Charges Miscellaneous. (If any specify) Amount of Total Estimate submitted by Hospital(Rs.)	

Part-III [Advance Amount Selection Clause]

	Sl. No.	Particulars	Amount (Rs.)
	1	Maximum admissible amount for Advance 80 % of (3.2+ 3.3+3.4)	
Ī	2	Amount of Advance Applied for	

Amount of	Advance Claim:[Lowest amount of Sl. No. 1 and 2 of Part-III]
Rs.	
In words:	Rupees

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclose	d or not
1	Enrolment Certificate of patient	Yes □	No □
2	Original Estimate issued by empanelled hospital for seeking advance	Yes □	No □
3	Prognosis Report of patient issued by Treating Specialist	Yes □	No □
4	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only)	Yes□	No □
5	Any other instruments (Specify)	Yes □	No□

Date:	Signature of the Teacher/Officer/Claimant	:
	Name in Block Letters:	
	Designation:	

In-Patient Department (IPD) treatment in recognised/empanelled/enlisted hospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid College and Universities under Department of Health & Family Welfare, Govt. of West Bengal

(As per Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)

(Generated by Teacher/Officer from WBHS Portal)

To

(Name of the Institution) (Office Address of Hol) Sir/Madam, I am submitting a prayer of Rs
ir/Madam, I am submitting a prayer of Rs
I am submitting a prayer of Rs
I am submitting a prayer of Rs
owards Advance of cost of In-Patient Department (IPD) treatment at recognised/empanelled/enliste ospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universitie inder Department of Health & Family Welfare, Govt. of West Bengal as per details stated below: Part-I[General Information] 1. Details of Teacher/Officer. Full Name
ospital under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities nder Department of Health & Family Welfare, Govt. of West Bengal as per details stated below: Part-I[General Information]
Part-I[General Information] 1. Details of Teacher/Officer. Full Name
Part-I[General Information] 1. Details of Teacher/Officer. Full Name
1. Details of Teacher/Officer. Full Name Enrollment ID No. Bed Entitlement Date of Enrolment Date of En
Full Name
available
Enrollment ID No. Bed Entitlement 2. Details of Patient, Treating Hospital 2.1 Name of Patient Beneficiary ID Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Address of Hospital 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure Claim Application ID. Date of Enrolment Beneficiary ID Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Class of Entitlement of Hospital Address of Hospital
Bed Entitlement 2. Details of Patient, Treating Hospital 2.1 Name of Patient Beneficiary ID Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Address of Hospital 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure Date of Enrolment
2. Details of Patient, Treating Hospital 2.1 Name of Patient Beneficiary ID Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Address of Hospital 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
2.1 Name of Patient Beneficiary ID Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure
Beneficiary ID Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
Relationship with Teacher/Officer 2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure
2.2 Name of Empanelled/Enlisted hospital where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
where treatment availed Code of Hospital Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
Code of Hospital Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
Class of Entitlement of Hospital Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
Address of Hospital Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
Part-II [Details of Cost Component of Estimate] 3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
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3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
3. Estimate of Hospital 3.1 No. of days for which hospital produced Estimated Expenditure () days
3.1 No. of days for which hospital produced Estimated Expenditure () days
Expenditure () days
3.2 ESUMATE COST OF PROCEDURAL / PACKAGE FREATMENT
Sl. No. Name of Procedures/ Packages Procedure Amount (Rs.)
Code
3.2.1
3.2.2
3.2.3
3.2.4
3.2.5
Total
3.3 Estimate cost of Implants Used

Sl. No. 3.3.1 3.3.2 3.3.3 3.3.4	Name of Implants	Coded or Non- coded	Implar Code, code	if	Amount (Rs.)
3.3.5					
			Total	(Rs.)	
3.4 Est	timate cost of Non-Procedural/ Non-		nt.		
Sl. No.	Name of C	Component			Amount (Rs.)
3.4.1	Room/ Bed Rent				
	ICCU/ITU/ICU/NICU/PICU	From	То		
	HDU/SDU	From	То		
	Burn Unit	From	То		
	CRIB	From	То		
	General/Semi-Private/Private	From	То		
3.4.2	Consultation Fees.				
3.4.3	Pathological and Radiological Invest	tigations.			
3.4.4	Medicines.				
3.4.5	Consumables				
3.4.6	Special Nursing/Aya Charges				
3.4.7	Miscellaneous. (If any specify)				
	Amount of Total Estimate submitted by Hospital(Rs.) (amount mentioned in 3.2+ 3.3+.4)				

Part-III [Advance Amount Selection Clause]

Sl. No.	Particulars	Amount (Rs.)
1	Maximum admissible amount for Advance 80 % of (3.2+ 3.3+3.4)	
2	Amount of Advance Applied for	

Amount of	f Advance Claim: [Lowest amount of Sl. No. 1 and 2 of Part-III]
Rs.	
In words:	Rupees

Part-IV [Details of Advance Claimant]

Sl. No.	Name of Claimant	Relation
1		

Part-V [Declaration of Teacher/Officer]

I hereby declare that the statements made in the application of claim for reimbursement is true to the best of my knowledge and belief. The person, for whom medical expenses incurred, is a beneficiary of the stated scheme and possessed a valid enrolment certificate at the time treatment. I will be responsible and liable for any disciplinary action taken against me in terms ofRules if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

[List of Enclosures]

Sl. No.	Name/Particulars of enclosures to be attached	Enclosed or not	
1	Original Estimate issued by empanelled hospital for seeking advance	Yes □	No □
2	Prognosis Report of patient issued by Treating Specialist	Yes □	No □
3	Any other instruments (Specify)	Yes□	No □

Date:		
	Signature of the Teacher/Officer/Claimant	:
	Name in Block Letters:	
	Designation:	

FORM-R CLAIM ID:

Government of West Bengal Department of Health & Family Welfare MERT Branch Swasthya Bhawan, Block – GN – 29, Salt Lake City, Sector – V, Kolkata -91

No:	Dated :

To

 The Principal Account General (A &E), West Bengal, Treasury Building, Kol-1.

2. Pay and Accounts Officer/Treasury Officer,(Name of PAO/Treasury), Address of Name of PAO/Treasury

SI. No.	Particulars	Details
1	Enrollment ID. of Teacher/Officer	
2	Name of Teacher/Officer	
3	Name of Patient	
4	Beneficiary ID of Patient	
5	Relationship with the Teacher/Officer	
6	Designation of Head of Institution	
7	DDO Code of Drawing & Disbursing Officer	
8	Designation of Drawing & Disbursing Officer	
9	Head of Account	"24-2210-Medical and Public Health-05-MEDICAL EDUCATION, TRAINING AND RESEARCH-105-Allopathy-074-Medical Reimbursement to the Teachers and Officers of State aided Universities-31-Grants-in-aid-GENERAL-02-Other Grants-V" under Demand No. 24 and Department Code "HF".
10	Type of Treatment	
11	Name of Hospital where treatment availed	
12	Type of Hospital	
13	Amount Claimed (Rs.)	
14	Amount Sanctioned in figure (Rs.)	
15	Amount Sanctioned in words (Rupees)	
16	Name of Claimant(In case of death) and Relation	NA

All others concerned are being requested to access WBHS portal using your login for verification and necessary action.

Space of DSC Stamping

Digitally Signed. Does not require any Ink Signature.

Annexure-I

Certification of Treating Specialist/Consultant of **Recognised/Empanelled/Enlisted** Hospital for claiming reimbursement of <u>"Out Patient Department(OPD)"</u> treatment under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under **Department of Health & Family Welfare**, Govt. of West Bengal.

1.	Certified that the Patient, Sri/S	mt, having Bene	ficiary ID		
		is a beneficiary of the scheme stated above.	•		
2.	S/he has been suffering from	specify	name of		
	disease) as listed in SI. No	of the OPD list as per 6(1) clause or follow-up medical attended	ance and		
	treatment of	as per 6(2) clause of Order No	dt		
	issued by Department of Health & Family Welfare, Govt. of West Bengal.				
3.	Date of consultation is	·			
	Date: S	ignature of Treating Specialist/Consultant:			
	F	Registration No. and Authority:			
		Name of Hospital:			
	(Official Spal of the Hospital:			

List of OPD (Out Patient Department) Diseases

As per clause 6(1) of			As per clause 6 (2) of		er clause 6 (2) of
Sl. No	Name of the Disease	SI. No	Name of Disease	Sl. No	Name of the Disease
1	Malignant Diseases.	10	Injuries Caused by Accident (including Animal Bite).	1	Neuro Surgery.
2	Tuberculosis.	11	Rheumatoid Arthritis.	2	Cardiac Surgery (Including Coronary Angioplasty and implants).
3	Hepatitis B/C and Other Liver Diseases.	12	Systematic Lupus Erytthematous (LUPUS).	3	Cancer Surgery/ Chemotherapy/ Radiotherapy.
4	Insulin Dependent Diabetes (Type-2 Diabetic Mellitus is not considered as Insulin Dependent Diabetes).	13	Crohn's Disease.	4	Renal Transplant.
5	Heart Diseases.	14	Endodontic Treatment (Root Canal Treatment).	5	Hip/ Knee replacement Surgery.
6	Neurological Disorder/ Cerebra Vascular Disorders.	15	COPD (Chronic Obstructive Pulmonary Disease).	6	Accident cases.
7	Malignant Malaria.	16	Ankylosing Spondylitis		
8	Renal Failure.	17	None of the above list [Vide para 10 of 797-F(MED), dated 31.01.2011]		
9	Thallasaemia/ Bleeding orders/ Platelet Disorders.				

^{**} In case of OPD treatment, where medicine is prescribed for indefinite period, Employee can submit his/her successive reimbursement claim with copy of this annexure only once.

Annexure-II

Certification of Medical Superintendent/Administrative Officer of treating <u>Non-Empanelled</u> <u>Hospital</u> for claiming reimbursement of only <u>"Indoor"</u> treatment under West Bengal Health Scheme for the Beneficiaries of Grant-in-Aid Colleges and Universities under **Department of Health & Family Welfare**, Govt. of West Bengal

1.	 Certified that the Patient, Sri/Smt. 			naving
	Beneficiary ID is a be			stated
	above and s/he availed an indoor treatment for period from	to	·	
2.	2. Certified that the Hospital/Nursing Home/Health () nos. of bed.	Care	Organisation	has
3.	 Certified that the Hospital/Nursing Home/Health Care Organisation West Bengal Clinical Establishment Act and Rules bearing no valid up to 			
	Date: Signature of Superintendent/Administra	ative Off	icer:	
	oignature of Superintendent, Naministre			
	Name of Hospital:			
	Official Seal of the Hospital:			