FORM – MRC (S)
(For serving employees)

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the Principal Card holder in BLOCK LETTERS)

1. (a) Name of the Principal CGHS Card Holder :
   (b) CGHS Ben ID No. :
   (c) Employee Code No. :
   (d) Ward Entitlement – Pvt./Semi-Pvt./General :
   (e) Full Address :

   (f) Mobile telephone No. and e-mail address, if any :

2. (a) Patient's Name :
   (b) Patient's CGHS Ben ID No. :
   (c) Relationship with the Principal CGHS card holder :

3. Name & address of the hospital / diagnostic center / imaging center where treatment is taken or tests done:

4. Whether the hospital/diagnostic/imaging center is empanelled under CGHS : Yes/No

5. Treatment for which reimbursement claimed
   (a) OPD Treatment /Test & investigations :
   (b) Indoor Treatment :

6. Whether treatment was taken in emergency : Yes/No

7. Whether prior permission was taken for the treatment : Yes/No

8. Whether subscribing to any health/medical insurance scheme, If yes, amount claimed/received : Yes/No

9. Details of Medical Advance taken, if any :

10. **Total amount claimed**
    (a) OPD Treatment :
    (b) Indoor Treatment :
    (c) Tests/Investigation :

11. Name of the Bank : ..... SB A/c No.: .....
    Branch MICR Code: ..... IFSC Code.....

DECLARATION

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

Date : .....

Place: ..... **Signature of the Principal CGHS card holder**