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

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.

Place

Date

Signature of the Principal Card Holder

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