Appendix 'J'
(Ref Para 10 (d)
of B/49779-Outsourcing/AG/ECHS
Dated Mar 2014)

FORM FOR REIMBURSEMENT OF MEDCIAL CLAIMS OF ECHS BENEFICIARIES

1. ECHS Registration No. .....
2. Full Name of the Card Holder .....
3. Full Address .....
4. Telephone No. .....
5. E-Mail Address .....
6. Name of the Bank..... Branch..... S/B Ac No.....
   Branch MICR Code..... Tele No of Bank Branch.....
7. Name of the patient & relationship with the card holder .....
8. Name of the Hospital with address: .....
   (a) OPD treatment and investigations .....
   (b) Indoor Treatment .....
9. Date of Admission ..... Date of discharge .....
10. Total amount claimed
    (a) OPD treatment and investigations .....
    (b) Indoor Treatment .....
11. Details of Referral .....
12. Details of Medical Advance, if any .....
13. The following documents are submitted (please tick the relevant column)

(a)	Photocopy of ECHS Card	:	Yes / No
(b)	No. of Original Bills	:	Yes / No
(c)	Copy of discharge summary	:	Yes / No
(d)	Copy of referral Specialist / SEMO	:	Yes / No
(e)	Whether the Hospital has given breakup for Lab investigations	:	Yes / No
(f)	Original papers have been lost the following Documents are submitted		
	(i) Photocopies of claim papers	:	Yes / No
	(ii) Affidavit on Stamp paper	:	Yes / No
(a)	In case of death of card holder, the following documents are submitted:-		
	(i) Affidavit on Stamp paper by Claimant	:	Yes / No
	(ii) No objection from other legal heirs on stamp papers	:	Yes / No
	(iii) Copy of death certificate	:	Yes / No

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and person for whom medical expenses were incurred is wholly dependant on me. I am a ECHS beneficiary and am agree for the reimbursement as is admissible under the rules.

Date:

Signature of ECHS Card Holder