NHPC RETIRED EMPLOYEES' HEALTH SCHEME

APPLICATION FOR REIMBURSEMENT OF MEDICAL EXPENSES (IN CASE OF INDOOR TREATMENT)

1.	Name of the retired/deceased employee		
2.	Employee Number		
3.	Date of Retirement/Death		
4.	Designation at the time of Retirement/Death		
5	Scale of pay with grade code and the basic pay on the date of retirement/death		
6.	Division/Office from where separated		
7.	Division / office where registered for medical benefits under the Scheme		
8.	Address		
9.	Medical Card Regn. No.		
10.	Name of the Patient		
11.	Place at which the patient fell ill		
12.	If treatment taken at a place other than the place of residence, explain the reason.		
13.	Name of the Hospital where treatment taken or the name of the AMA consulted		
14.	Total amount claimed		

Details of the amount claimed	Amount claimed	Amount admitted
i) Accommodation charges : (excluding diet charges)		
ii) Surgical operation / Medical Treatment		
iii)Pathological,Bacteriological,Radiological or other tests (with full details)		
iv)Cost of medicines and injections purchased from the market supported by cash memos and receipts.		
v) Any other charges : (Attach details & proof) ..		
Total :		

DECLARATION BY THE CLAIMANT

I hereby declare that :

i. The statements made in the claim are true to the best of my knowledge and belief.

ii. I am a member of the NHPC Retired Employees Health Scheme.

iii. I continue to fulfill the conditions of eligibility for availing the medical benefits under the scheme.

iv. The medical expenses were incurred for self / spouse/children(in case of deceased employee).

v. That children (in case of deceased employee) are not employed. Their income from all sources does not exceed to Rs.6000/-, they have not attained the age of 25 in case of son and 30 in case of daughter and are not married/The child/children named _____ is/are physically handicapped / mentally retarded.

vi. That no claim is preferred in respect of diseases as listed in Rule 10.4.1 to 10.4.6.

vii. I fully understand that the Company may refuse / terminate my membership of the Scheme at any time without any notice and without assigning any reason thereof.

Certified that I am not re-employed on full time basis elsewhere and am not availing medical cover in consequence of employment of my spouse or as dependent of my ward(s).

Date: ..... Signature of the claimant

I, Dr. ..... for ..... Hospital confirm that no expenditure on treatment of following account is being claimed by the patient ;

Venereal disease, Psychiatric treatment, intentional self-injury intemperance or the use of intoxicating drugs or liquor or any injury, disease or illness directly or indirectly attributable to one or more of these causes.

i. Treatment of congenital defects / diseases, if these are incurable are not covered in above.
ii. Expenditure on treatment pertaining to menopause are not covered in above bill.
iii. Expenditure on special nursing are not covered in above bill.
iv. Expenditure towards cosmetic Surgery are not covered in above bill

The identity of Sh./ Smt..... who has taken the treatment (Patient) has been verified from the Medical Card No..... of NHPC and his / her signatures are verified.

Signature of patient Authorised signatory of the Hospital with stamp

FOR USE IN OFFICE

Admitted for Rs..... Passed for..... Paid by Cheque No.....
for Rs..... .

Signature