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 **Dated: Kolkata, the 21st June, 2021**

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.

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. <u>Enrolment:</u>

(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. <u>Criteria for Reimbursement of Claims:</u>

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. <u>Accommodation/Entitlement:</u>

(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. No.	Category of Beneficiary	Range of Basic Salary as per ROPA-2019	Type of Accommodation
1	I	Rs.1,50,000/- & More.	**i)Pay Bed in Govt. Hospitals :** Single Occupancy Large 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/- & more but less than Rs. 1,50,000/-	**i)Pay Bed in Govt. Hospitals:** Single Occupancy Small Cabin **ii)Tata Medical Center, Rajarhat :** General Bed **iii)Other Private Empanelled HCOs:** Private Room/ Private Cabin /Private Bed
3	III	Rs. 45,000/- & more but less than Rs. 75,000/-	**i) Pay Bed in Govt. Hospitals:** Double Occupancy Large Cabin **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	O P D
Head of the Administrative Department (Addl. Chief Secretary/Principal Secretary/Secretary) for both College & University.	Full 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

No. HF/O/MERT/594/HFW-24011(13)/2/2020/1(10) **Dated: Kolkata, the 21st June, 2021**

Copy forwarded for information and necessary action to:

1. Accountant General (A&E), West Bengal, Treasury Building, Kolkata -700001.
2. 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.
5. 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.
8. 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.
5. 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.
10. 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.
13. 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

To
The .... (Designation of Head of Institution)
.... (Name of the Institution)
.... (Office Address of Head of Institution)

I, Sri/Smt./Miss ………………………………….. (Name of Teacher/Officer) ………………………….. (Designation) do hereby opt for coming 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** with effect from…………………………..

The particulars of me are stated herein under:

Sl. No.	Particulars	Details
1	Name of Teacher/Officer	
2	Application ID	
3	Designation	
4	Gender	
5	Marital Status	
6	Residential Address	
7	Date of Birth	
8	Date of Entry into University	
9	Date of Superannuation	
10	Basic Pay/Basic Salary (As per ROPA 2009 or 2019)	
11	DDO Code of Head of Institution	
12	Mobile No.	
13	E-Mail Address	
14	Voter Card/ PAN/Aadhar No.	
15	Bank details for claim disbursement	

Details of eligible family members including me are given below:

Sl. No.	Name	Date of Birth	Relation	Beneficiary ID	Blood Group	Photo	Signature

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:

FORM-B

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

MemoNo. **Date:**

Information of Teacher/ Officer

1.	Name (In Block Letter)		2.	Enrolment ID.	
3.	Designation of Teacher/ Officer		4.	Date of Entry into College/University	
5.	Address of Teacher/ Officer		6.	Date of Superannuation	

Hospital Accommodation Entitlement

1.	Pay Bed in Government Hospital run by Govt. of West Bengal	
2.	Tata Medical Centre, Rajarhat	
3.	Other Private Empanelled HCOs	

Information of Beneficiaries (Including Teacher/ Officer)

1.	Name of Beneficiary	Beneficiary ID : Relation With Teacher/ Officer: Date of Birth: Blood Group:	Space for Photo	Enrollment w.e.f.: Mobile No. : Email: Aadhaar No. :	Space for Signature
2.	Name of Beneficiary	Beneficiary ID : Relation With Teacher/ Officer: Date of Birth: Blood Group:	Space for Photo	Enrollment w.e.f.: Mobile No. : Email: Aadhaar No. :	Space for Signature
3.	Name of Beneficiary	Beneficiary ID : Relation With Teacher/ Officer: Date of Birth: Blood Group:	Space for Photo	Enrollment w.e.f.: Mobile No. : Email: Aadhaar No. :	Space for Signature
4.	Name of Beneficiary	Beneficiary ID : Relation With Teacher/ Officer: Date of Birth: Blood Group:	Space for Photo	Enrollment w.e.f.: Mobile No. : Email: Aadhaar No. :	Space for Signature

List of Beneficiary with Critical Diseases (If Any)

Beneficiary Name	Beneficiary 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.

Manual Application Form

HF GIA Form -C1

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)

To
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs.................. (Rupees..) towards reimbursement of cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I [General Information]

1. Details of Teacher/Officer.			
Full Name (in Block letters)		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any.		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes ☐ No ☐ Not known ☐

3. Details of Claimant *(Applicable in case of death of employee)*		
Sl. No.	Name of claimant	Relation
3.1		

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

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

5. Details of OPD Treatment					
Sl. No.	**Particulars**	**Details**			
5.1	Category of OPD Claim (Tick mark in appropriate box)*[See list of diseases/illness mentioned in clause 6(1) and 6(2)]*	As per clause 6(1) of OPD List	☐	As per clause 6(2) of OPD List	☐
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment				
5.3	Date of OPD consultation				

6. Expenditure Statement of OPD treatment		
Sl. No.	Name of Components	Amount Claimed (Rs.)
6.1	**Procedure Charges**	
6.2	**Consultation Fees**	
6.3	Cost of Pathological and Radiological Investigations	
6.4	**Cost of Medicines**	
6.5	**Cost of Implant / Special Device**	
6.6	**Miscellaneous (specify)**	
	Total	
	No. of Vouchers	

6.1 Procedure Charges:

Sl. No.	Name of Procedure	Procedure Code	Amount Admissible (Rs)

6.3 Cost of Pathological and Radiological Investigations:

Sl. No.	Name of Investigation	Coded / Non-Coded	Code of Investigation	Amount Admissible (Rs)

6.4 Cost of Medicines:

Period of medicine consumption	From		To	

6.5 Cost of Implant / Special Device:

Sl. No.	Name of Implant / Special Device	Code of Implant / Special Device	Amount Admissible (Rs)

Part-III [Medical Advance]

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

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (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 of ....Rules 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	**Annexure-I** duly signed with proper stamp by Treating Specialist of 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 only for claiming reimbursement of Digital Hearing Aid).***	Yes ☐	No ☐
9	In case of death of Teacher/Officer; a. An, affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ 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 ☐

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Online Application Form

HF GIA Form -C1

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
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)
Sir/Madam,

I am submitting a claim of Rs................... (Rupees………………………………..................………) towards reimbursement for cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any.		
2.1	Name of Patient	
	Beneficiary ID	
	Relationship with Employee	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed.	
	Code of Hospital	
	Class of Entitlement of Hospital	
	Address of Hospital	
2.3	Requirement of approval of delay Condonation, if any(Tick mark in appropriate box)	Yes ☐ No☐ Not known☐

3. Detail of Claimant *(Applicable in case of death of employee)*		
Sl.No.	Name of claimant	Relation
3.1		

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

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

5. Details of OPD Treatment					
Sl. No.	**Particulars**	**Details**			
5.1	Category of OPD Claim (Tick mark in appropriate box) *[See list of diseases/illness mentioned in clause 6(1) and 6(2)]*	As per clause 6(1) of OPD List	☐	As per clause 6(2) of OPD List	☐
5.2	Name of OPD Disease/ Type of follow-up medical attendance and treatment				
5.3	Date of OPD consultation				

6. Expenditure Statement of OPD treatment						
Sl. No.	Name of Components					Amount Claimed (Rs.)
6.1	**Procedure Charges**					
	Sl. No.	Name of Procedure	Procedure Code	Amount Admissible (Rs)		
6.2	**Consultation Fees**					
6.3	Cost of Pathological and Radiological Investigations					
	Sl. No.	Name of Investigation	Coded / Non-Coded	Code of Investigation	Amount Admissible (Rs)	
6.4	**Cost of Medicines**					
	Period of medicine consumption	From		To		
6.5	**Cost of Implant / Special Device**					
	Sl. No.	Name of Implant / Special Device	Code of Implant / Special Device	Amount Admissible (Rs)		
6.6	**Miscellaneous (specify)**					
					Total	
					No. of vouchers	

Part-III [Medical Advance]

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

Part-IV [Refund of Medical Advance]

8. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (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 of ....Rules 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	**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 b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
9	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Manual Application Form

HF GIA Form –C2

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)

To
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs.................. (Rupees...) towards reimbursement of cost of In-Patient Department (IPD) treatment at non-empanelled hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name (in Block letters)		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID *(To be filled at the time of online entry from end the Head of Office)*	

2. Detail of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Non-Empanelled/hospital where treatment was availed.	
2.3	Requirement of approval of delay Condonation, if Any(Tick mark in appropriate box)	Yes ☐ No ☐ Not known ☐

3. Detail of Claimant *(Applicable in case of death of employee)*		
Sl. No.	Name of claimant	Relation
3.1		

Part-II [Details and Expenditure Statement of IPD treatment]

4. Period of treatment			
Admission Date		Discharge 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		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	☐

6.2	Only Non- Procedural/ Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	☐

6.1 Details of Procedural/ Package Treatment					
Period of Procedural/ Package Treatment		From		To	
Sl. No	Name of Procedures/ Packages			Amount Claimed (Rs.)	
6.1.1					
6.1.2					
6.1.3					
6.1.4					
6.1.5					
			Total		

6.2 Details of Implants Used		
Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment						
Period of Non-Procedural/ Package Treatment		From		To		
Sl. No.	Name of Components					Amount Claimed (Rs.)
6.3.1	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		
6.3.2	Consultation Fees					
6.3.3	Pathological and Radiological Investigations					
6.3.4	Medicines					
6.3.5	Consumables					
6.3.6	Special Nursing/Aya Charges					
6.3.7	Miscellaneous. (If Any Specify)					
					Total	
					No. of Vouchers	
					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		

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 of ....Rules 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	**Annexure-II** duly signed with proper stamp by the Medical Superintendent / Administrative Officer of a Non-Empanelled Hospital	Yes ☐	No ☐
2	Enrolment Certificate of beneficiary	Yes ☐	No☐
3	Bill Summary	Yes ☐	No ☐
4	Original Money Receipts in chronological dates	Yes ☐	No ☐
5	Copy of Discharge Summary (case summary and copy of death certificate in case of death) and OT note	Yes ☐	No ☐
6	Detailed Bill	Yes ☐	No ☐
7	Original copy of Voucher/ Tax Invoice of Implants used	Yes ☐	No ☐
8	Copy of all investigation/ test reports sequentially	Yes ☐	No ☐
9	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 ☐
10	In case of death of Teacher/Officer; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
11	Filled ECS mandate form in case of those, whose bank details is not available in IFMS (in case of first claim only)	Yes ☐	No ☐
12	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Teacher/Officer/Claimant:

Name in Block Letters:

Designation:

Online Application Form

HF GIA Form –C2

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)

(Generated by Teacher/Officer from WBHS Portal)

To
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs................... (Rupees…………………..…………….) towards reimbursement for cost of In-Patient Department (IPD) treatment at Non-Empanelled hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID	
Bed Entitlement		Date of Enrolment	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
	Beneficiary ID	
	Relationship with Teacher/Officer	
2.2	Name of Non-Empanelled/hospital where treatment was availed.	
	Bed Capacity of Hospital	
	CE Licence No.	
	CE Licence valid up to	
	Address of Hospital	
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes ☐ No ☐ Not known ☐

3. Details of Claimant *(Applicable in case of death of employee)*		
Sl.No.	Name of claimant	Relation
3.1		

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

4. Period of treatment			
Admission Date		Discharge 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		
Sl. No.	Type of Treatment	Tick mark in appropriate box
6.1	Only Procedural/ Package Treatment	☐

6.2	Only Non- Procedural/ Package Treatment	☐
6.3	Both Procedural/ Package and Non- Procedural/ Package Treatment	☐

6.1 Details of Procedural/ Package Treatment

Period of Procedural/ Package Treatment	From		To	

Sl. No	Name of Procedures/ Packages	Amount Claimed (Rs.)
6.1.1		
6.1.2		
6.1.3		
6.1.4		
6.1.5		
	Total	

6.2 Details of Implants Used

Sl. No.	Name of Implants	Amount Claimed (Rs.)
6.2.1		
6.2.2		
6.2.3		
6.2.4		
	Total	

6.3 Details of Non-Procedural/ Package Treatment

Period of Non-Procedural/ Package Treatment	From		To	

Sl. No.	Name of Components					Amount Claimed (Rs.)
6.3.1	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		
6.3.2	Consultation Fees					
6.3.3	Pathological and Radiological Investigations					
6.3.4	Medicines					
6.3.5	Consumables					
6.3.6	Special Nursing/Aya Charges					
6.3.7	Miscellaneous. (If Any Specify)					
	Total					
	No. of Vouchers					
	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		

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 of ....Rules 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	
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 b. No objection from other legal heirs on stamp papers c. Copy of death certificate	 Yes ☐ Yes ☐ Yes ☐	 No ☐ No ☐ No ☐
10	Any other instruments (Specify)	Yes ☐	No ☐

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

HF GIA Form –C3

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
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs................... (Rupees...) towards reimbursement of cost of non-cashless In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name *(in Block letters)*		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed	
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes ☐ No ☐ Not Known ☐

3. Details of Claimant *(applicable in case of death of employee)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details (If any)		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal*[see 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]*	Permission ID : Permission approved for:
4.2	For treatment availed in enlisted hospital outside West Bengal *(see clause 12 of* Notification No. HF/O/MERT/594/HFW-24011(13)/2/2020 Dated: Kolkata, the 21st June, 2021)	Memo No. : Date: Designation / Authority : U.O. No. and date of Finance Deptt. West Bengal, if any:

Part-II [Expenditure Statement of IPD treatment]

5. Details of Treatment in Reimbursement Mode			
Period of treatment	Admission Date		Discharge date	

6. Type of Discharge					
Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal	☐	6.3	Referral	☐
6.2	Risk Bond	☐	6.4	Death	☐

7.Amount Claimed for		
Sl. No.	Type of Treatment	(Tick mark in appropriate box)
7.1	Only Procedural/ Package Treatment	☐
7.2	Only Non- Procedural/ Non-Package Treatment	☐
7.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment	☐

7.1 Details of Procedural/ Package Treatment			
Period of Procedural/ Package Treatment	From		To
Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount Claimed(Rs.)
7.1.1			
7.1.2			
7.1.3			
7.1.4			
7.1.5			
		Total	

7.2 Details of Implants Used				
Sl.No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)
7.2.1				
7.2.2				
7.2.3				
7.2.4				
7.2.5				
			Total (Rs.)	

7.3 Details of Non-Procedural/ Non-Package Treatment.						
Period of Non-Procedural/ Non-Package Treatment.		From		To		
Sl. No.	Name of Component					Amount Claimed (Rs.)
7.3.1	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		
7.3.2	Consultation Fees.					
7.3.3	Pathological and Radiological Investigations.					
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)	
	No. of vouchers	

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

8. Indoor related OPD treatment		
Do you want to claim Indoor related OPD treatment cost i.e. cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes ☐**	**No☐**

9. Details of Indoor related OPD Consultation	
Dates	Nos. of Consultation

10. Details Expenditure of Indoor related OPD treatment						
Sl. No.	Name of Components					Amount Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Investigations					
10.3	Cost of Medicines					
	Period of medicine consumption	From		To		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
	Total claim of indoor related OPD(Rs.)					
	Nos. of vouchers					

Part-IV [Medical Advance]

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

Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (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 of ....Rules 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	
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 b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes ☐ Yes ☐ Yes ☐	No ☐ No ☐ No ☐
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 ☐

Date:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

HF GIA Form –C3

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)

To
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a claim of Rs................... (Rupees...) towards reimbursement for cost of non-cashless In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		Date of Enrolment	

2. Details of Patient, Treating Hospital and Condonation Requirement, if any		
2.1	Name of Patient	
	Beneficiary ID	
	Relationship with Teacher/Officer	
2.2	Name of Empanelled/Enlisted hospital where treatment was availed.	
	Code of Hospital	
	Class of Entitlement of Hospital	
	Address of Hospital	
2.3	Requirement of approval of delay Condonation, if any (Tick mark in appropriate box)	Yes ☐ No ☐ Not Known ☐

3. Details of Claimant *(applicable in case of death of employee)*		
Sl. No.	Name of claimant	Relation
3.1		

4. Permission Details (If any)		
Sl. No.	Permission sought	Details of permission approval
4.1	For treatment availed in empanelled private hospital within West Bengal [*see 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]*	Permission ID : Permission approved for:

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

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

5. Details of Treatment in Reimbursement Mode			
Period of treatment	Admission Date		Discharge date	

6. Type of Discharge					
Sl. No.	Type of Discharge	(Tick mark in appropriate box)	Sl. No.	Type of Discharge	(Tick mark in appropriate box)
6.1	Normal	☐	6.3	Referral	☐
6.2	Risk Bond	☐	6.4	Death	☐

7. Amount Claimed for		
Sl. No.	Type of Treatment	(Tick mark in appropriate box)
7.1	Only Procedural/ Package Treatment	☐
7.2	Only Non- Procedural/ Non-Package Treatment	☐
7.3	Both Procedural/ Package and Non- Procedural/ Non-Package Treatment	☐

7.1 Details of Procedural/ Package Treatment				
Period of Procedural/ Package Treatment	From		To	
Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount Claimed(Rs.)	
7.1.1				
7.1.2				
7.1.3				
7.1.4				
7.1.5				
		Total		

7.2 Details of Implants Used				
Sl. No.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount Claimed (Rs.)
7.2.1				
7.2.2				
7.2.3				
7.2.4				
7.2.5				
			Total (Rs.)	

7.3 Details of Non-Procedural/ Non-Package Treatment.					
Period of Non-Procedural/ Non-Package Treatment.		From		To	
Sl. No.	Name of Components				Amount Claimed (Rs.)
7.3.1	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		
7.3.2	Consultation Fees.					
7.3.3	Pathological and Radiological Investigations.					
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)	
					No. of vouchers	

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

8. Indoor related OPD treatment		
Do you want to claim Indoor related OPD treatment cost i.e. cost of OPD treatment 30 days prior to admission and 30 days after discharge? (Tick mark in appropriate box)	**Yes ☐**	**No ☐**

9. Details of Indoor related OPD Consultation	
Dates	Nos. of Consultation

10. Details Expenditure of Indoor related OPD treatment						
Sl. No.	Name of Components					Amount Claimed (Rs.)
10.1	Consultation Fees					
10.2	Cost of Pathological and Radiological Investigations					
10.3	Cost of Medicines					
	Period of medicine consumption	From		To		
10.4	Cost of Special Device					
10.5	Miscellaneous (specify)					
					Total claim of indoor related OPD(Rs.)	
					Nos. of vouchers	

Part-IV [Medical Advance]

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

Part-V [Refund of Medical Advance]

12. Details of Refund of Medical Advance, if any					
Name of Treasury from where it was drawn	DDO Code	Designation of DDO	Treasury Challan No.	Treasury Challan Date	Amount (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 of ....Rules 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	
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 OPD treatment in sequence manner (In chronological order)	Yes ☐	No ☐
10	In case of death of Teacher/Officer; a. An affidavit on stamp paper by claimant b. No objection from other legal heirs on stamp papers c. Copy of death certificate	Yes ☐ Yes ☐ Yes ☐	No ☐ No ☐ No ☐
11	Any other instruments (Specify)	Yes ☐	No ☐

Date:

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

Designation:

Manual Advance Application Form

HF GIA Form –C4

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)*

To
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs................... (Rupees…………………………………………………..........….………) towards **Advance** of cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name (in Block letters)		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. Details of Patient, Treating Hospital.		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital from where estimate is received.	

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital							
3.1 No. of days for which hospital produced Estimated Expenditure		☐ ( ) Days					
3.2 Details of OPD Diseases for which advance is sought							
Sl. No.	**Particulars**	**Name of diseases**					
3.2.1	Name of OPD Diseases for which advance is required(Tick mark in appropriate box)	☐	BetaThallsaemia	☐	*Hepatitis C*	☐	*Carcinoma including Multiple Myelomas*

4. Cost Component of OPD treatment as per estimate submitted by Empanelled/Enlisted hospital					
Sl. No.	Name of Component	Nos.	Period		Amount (Rs.)
			From	To	
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]

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 of ....Rules 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	
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:

Signature of the Teacher/Officer/Claimant :

Name in Block Letters:

Designation:

Online Advance Application Form

HF GIA Form –C4

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)*

To
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)
Sir/Madam,

I am submitting a prayer of Rs................... (Rupees…………………..…………) towards advance for cost of Out-Patient Department (OPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		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 is 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	
3.2 Details of OPD Diseases for which advance is sought		

Sl. No.	**Particulars**	**Name of diseases**					
3.2.1	Name of OPD Diseases for which advance is required (Tick mark in appropriate box)	☐	Beta Thallsaemia	☐	*Hepatitis C*	☐	*Carcinoma including Multiple Myelomas*

4. Cost Component of OPD treatment as per Estimate submitted by Empanelled/Enlisted hospital					
Sl. No.	Name of Component	Nos.	Period		Amount (Rs.)
			From	To	

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]

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 of ....Rules 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	
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:

HF GIA Form –C5

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
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs................... (Rupees…………………………………………………..........................……………) towards **Advance** of cost of In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name *(in Block letters)*		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID. *(To be filled at the time of online entry from the end of Head of Office)*	

2. **Details of Patient, Treating Hospital**		
2.1	Name of Patient	
2.2	Name of Empanelled/Enlisted hospital where treatment availed	

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital	
3.1 No. of days for which hospital produced Estimated Expenditure	☐ **( ) days**

3.2 Estimate cost of Procedural/ Package Treatment			
Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount (Rs.)
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.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount (Rs.)

3.3.1				
3.3.2				
3.3.3				
3.3.4				
3.3.5				
			Total (Rs.)	

3.4 Estimate cost of Non-Procedural/ Non-Package Treatment.						
Sl. No.	Name of Component					Amount (Rs.)
3.4.1	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		
3.4.2	Consultation Fees.					
3.4.3	Pathological and Radiological Investigations.					
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+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 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 of ....Rules 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	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:

HF GIA Form –C5

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
The .... (Designation of HoI)
.... (Name of the Institution)
.... (Office Address of HoI)

Sir/Madam,

I am submitting a prayer of Rs................... (Rupees...) towards **Advance** of cost of In-Patient Department (IPD) treatment at recognised/empanelled/enlisted hospital 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 as per details stated below:

Part-I[General Information]

1. Details of Teacher/Officer.			
Full Name		HRMS ID (If available)	
Enrollment ID No.		Claim Application ID.	
Bed Entitlement		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	

Part-II [Details of Cost Component of Estimate]

3. Estimate of Hospital			
3.1 No. of days for which hospital produced Estimated Expenditure		**☐ ( ) days**	
3.2 Estimate cost of Procedural / Package Treatment			
Sl. No.	Name of Procedures/ Packages	Procedure Code	Amount (Rs.)
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.	Name of Implants	Coded or Non-coded	Implants Code, if coded	Amount (Rs.)
3.3.1				
3.3.2				
3.3.3				
3.3.4				
3.3.5				
			Total (Rs.)	

Sl. No.	Name of Component					Amount (Rs.)
3.4	**Estimate cost of Non-Procedural/ Non-Package Treatment.**					
Sl. No.	Name of Component					Amount (Rs.)
3.4.1	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		
3.4.2	Consultation Fees.					
3.4.3	Pathological and Radiological Investigations.					
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 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 of ....Rules 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

1. 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

Sub:- Sanction order for Reimbursement of Medical Expenditure of ……………….. (Name of Teacher/Officer) ……………………………………….. (Designation) 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.

Sl. 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 **"Out Patient Department(OPD)"** 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.____, having Beneficiary ID ____ is a beneficiary of the scheme stated above.
2. S/he has been suffering from ____(specify name of disease) as listed in Sl. No.____ of the OPD list as per 6(1) clause or follow-up medical attendance 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: **Signature of Treating Specialist/Consultant:**

Registration No. and Authority:

Name of Hospital :

Official Seal of the Hospital:

List of OPD (Out Patient Department) Diseases

As per clause 6(1) of……………………………….				**As per clause 6 (2) of ……………**	
Sl. No	**Name of the Disease**	**Sl. 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 **Non-Empanelled Hospital** for claiming reimbursement of only **"Indoor"** 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.____, having Beneficiary ID ____ is a beneficiary of the scheme stated above and s/he availed an indoor treatment for period from ________ to ___________.

2. Certified that the Hospital/Nursing Home/Health Care Organisation has ________________________ (   ) nos. of bed.

3. Certified that the Hospital/Nursing Home/Health Care Organisation obtained a License under the West Bengal Clinical Establishment Act and Rules bearing no. _____________ and this License is valid up to ____________.

   Date:

Signature of Superintendent/Administrative Officer:

Name of Hospital:

Official Seal of the Hospital: