

दिल्ली कौशल एवं उद्यमिता विश्वविद्यालय
DELHI SKILL AND ENTREPRENEURSHIP UNIVERSITY
(A State University Established under Govt. of NCT of Delhi Act 04 of 2020)
Integrated Institute of Technology Complex
Sector 9, Dwarka, New Delhi – 110077

F.No.23(3)/Medical/DSEU/2023/1497

Date: 19.01.23

CIRCULAR

Sub: Procedure for submission of Medical Bills for Re-imburement

It is to inform that for smooth disposal with a motive to increase the transparency and avoid any kind of discrepancy in the process vis-à-vis disposal of medical bills re-imburement cases, a Bill Summary Performa (copy enclosed) duly filled by the claimant needs to be attached along with the medical bills re-imburement claim prior to submission in the department.

Therefore, all the DGEHS beneficiaries are hereby advised to submit the Medical Bill Re-imburement Claim (In Duplicate), separately for each beneficiary, in prescribed format and in chronological order as appended here below henceforth:

1. Annexure-I: Check List for Re-imburement of Medical Claims (Copy Enclosed)
 2. Annexure-II: Revised Medical 2004 Form (Copy Enclosed)
 3. Copy of Medical Card
 4. Dull Filled Bill Summary Performa
 5. OPD Consultation Voucher (if applicable)
 6. OPD Prescription/ IPD detailed bill summary
 7. Emergency Certificate (in case of Non-Empanelled hospital)
 8. N/A Certificate from attached dispensary/hospital
 9. Medical and Investigation Vouchers/Bills (in original)
 10. Updated RTGS/NEFT Details
- (* All documents mentioned above should be self-attested.)

Encl: As above



(Deepak Dahiya)
Dy. Registrar (Admin)

F.No.23(3)/Medical/DSEU/2023/1497
Copy to:

Date: 19.01.23

1. All Campus Directors, DSEU
2. Dy. Registrar (Admin/H.R/Academics)
3. DCA, DSEU
4. DDO, DSEU
5. All OSDs
6. OSD (IT), for uploading on website
7. PS to VC
8. PA to Registrar
9. Guard File



(Deepak Dahiya)
Dy. Registrar (Admin)

**DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME
MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS**

1. DGEHS Card No. and Place of Issue: -
2. Validity of DGEHS Card from.....to.....
3. Ward Entitlement (if Admitted in Hospital): - Private. / Semi Private. / General
4. Full Name of Employee/Beneficiary (Block Letters):-
5. Designation:-
6. The following documents are submitted: - (Please tick (√) the relevant column)
- | | |
|---|--------|
| a) Revised Medical 2004 Form:- | Yes/No |
| b) Photocopy of DGEHS Card showing validity (Emp. /Patient): - | Yes/No |
| c) Photocopy of Referral/ Authorization form AMA:- | Yes/No |
| d) Original Bills: - | Yes/No |
| e) Copy of prescription for OPD cases / Discharge Summary for Indoor cases:- | Yes/No |
| f) Breakup for Lab Investigation:- | Yes/No |
| g) Breakup of Drugs prescribed:- | Yes/No |
| h) Emergency Certificate from Hospital Empanelled / Registered with Government in case of
Emergency Admission: - | Yes/No |
| i) Self explanatory letter showing the need of emergency visit (in emergency cases): - | Yes/No |
| j) Non Availability Certificate from AMA (attached Dispensary / Hospital) for drugs prescribed in
OPD's :- | Yes/No |
| k) Original papers have been lost the following Documents are submitted: - | Yes/No |
| i. Photocopies of Claim Papers:- | Yes/No |
| ii. Affidavit on Stamp Paper: - | Yes/No |
| l) In case of Death of Card Holder the following Documents are submitted:- | Yes/No |
| i. Affidavit on Stamp Paper by Claimant: - | Yes/No |
| ii. No objection from other legal Heirs on Stamp paper :- | Yes/No |
| iii. Copy of Death Certificate:- | Yes/No |
7. Name of the Bank.....Branch.....SB A/C No.....
Branch MICR Code.....IFS Code..... Tel. No. of Bank Branch.....

Dated:-

Signature of DGEHS Card Holder

Telephone No. (M)..... (O).....E-Mail ID:-.....

Note: -

1. Kindly enclose Photocopy of Cancelled Cheque for online transfer of money to the account of beneficiary.
2. Provide one original copy and two photocopies of complete set of claim.

DELHI GOVERNMENT EMPLOYEES HEALTH SCHEME
REVISED MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF DGEHS BENEFICIARIES
 (To be filled by the claimant)

1. DGEHS Card No. and Place of issue:-
2. Validity of DGEHS Card: - from.....to.....
3. Ward Entitlement (if Admitted in Hospital): - Private. / Semi Private. / General.
4. Full Name of Employee/Beneficiary (Block Letters):- Mr./Ms.
5. Full Address:--
6. Telephone No. (O)..... (M).....
7. E-mail Address if, any:
8. Name of the Bank.....Branch.....SB A/C No.....
 Branch MICR Code.....IFS Code..... Tel. No. of Bank Branch.....
9. Name of the Patient & Relationship with the Card Holder:-
10. Basic Pay (Excluding Grade Pay):-
11. Name of the Hospital with Address:-
 (a) OPD Treatment (Investigations) & Period of treatment:-
 (b) Indoor Treatment:- Date of Admission.....Date of Discharge.....
12. Total Amount Claimed: - Total Rs.

Total Amount Claimed	Consultation Charges	Investigation Charges	Medicine Charges	Other Charges
For OPD Treatment				
For Indoor Treatment				

13. Details of Referral:-
14. Details of Medical Advance if, any:-

DECLARATION

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

Dated:-**Signature of DGEHS Card Holder**

Note: Misuse of DGEHS facilities is a criminal offence. Suitable action including cancellation of DGEHS card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.

