DELHI GOVERNMENT EMPLOYEE HEALTH SCHEME
REVISED MEDICAL 2004 FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS DGEHS BENEFICIARIES

(To be filled by the claimant)

1. DGEHS Card No. and place of issue

2. Validity of DGEHS Card : from……to……..
& Entitlement Pvt. / Semi Pvt./General

3 Full name of Employee/Beneficiary (Block Letters) :

4 DESIGNATION :

5. Full address :

6. Telephone no. (O)…… (M)

7. E-mail address if, any.

8. Name of the Bank ……. …… Branch……SB A/C
Branch MICR 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:
OPD treatment and investigations.
Indoor Treatment.

12. Date of admission……..Date of discharge……
(In case of Indoor Treatment only)

13. Total amount Claimed
OPD Treatment.
Indoor Treatment.

14. Details of Referral :

15. Details of Medical advance if, any:

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly 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:..…/…../20 **Signature of DGEHS card holder**