TRANSACTION ID :-

FORM-H

INFORMATION SHEET FOR CASHLESS INDOOR MEDICAL TREATMENT

NAME OF HCO WITH CODE NUMBER :-

DISTRICT OF HCO :-

DECLARATION OF GOVERNMENT EMPLOYEE AS PER THE PROVISIONS OF WEST BENGAL HEALTH FOR ALL EMPLOYEES AND PENSIONERS CASHLESS MEDICAL TREATMENT SCHEME,2014

1. NAME OF THE GOVERNMENT EMPLOYEE:-
2. ENROLLMENT ID:-
3. NAME OF PATIENT WITH IDENTIFICATION NUMBER:- ,EWREWRWE
4. ADMISSION DATE:-
5. DISCHARGE DATE:-
6. PERMANENT ADDRESS:-
7. CORRESPONDENCE ADDRESS:-
8. RESIDENCE PHONE NUMBER/MOBILE NUMBER:-
9. NAME OF THE DEPARTMENT:-
10. DRAWING AND DISBURSING OFFICER:-
11. OFFICE PHONE NUMBER:-
12. OFFICE EMAIL ID:-
13. OFFICE ADDRESS:-
14. NAME OF THE ACCOMPANYING PERSON(IF ANY):-
15. MOBILE NUMBER OF THE ACCOMPANYING PERSON:-
16. TOTAL TREATMENT COST:- **Rs. /-**
17. INSURANCE APPROVAL/DISCOUNT/REBATE AMOUNT:- **Rs. /-**
18. AMOUNT RECEIVED FROM GOVT. EMPLOYEE (FOR TREATMENT COST UPTO Rs 1 LAKH/-):- **Rs. /-**
19. AMOUNT CLAIMED TO STATE GOVERNMENT:- **Rs. /-**
20. AMOUNT RECEIVED FROM GOVERNMENT EMPLOYEE (FOR TREATMENT COST EXCEEDING Rs 1 LAKH/-):- **Rs. /-**

I HEREBY DECLARE THAT THE FURNISHED INFORMATION HEREIN ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHER DECLARE THAT I SHALL ABIDE BY THE PROVISIONS OF WEST BENGAL HEALTH FOR ALL EMPLOYEES AND PENSIONERS CASHLESS MEDICAL TREATMENT SCHEME,2014 AS MAY BE IN FORCE FROM TIME TO TIME.

SIGNATURE OF GOVERNMENT EMPLOYEE

1/9/2019 3:14:38 PM

COUNTERSIGNED BY MEDICAL SUPERINTENDENT/ADMINISTRATIVE OFFICER OF WITH SEAL

SIGNATURE OF THE TREATING SPECIALIST WITH OFFICE SEAL