



Medical Reimbursement Claims

Satyawati College
(University of Delhi)

NOTIFICATION

[List of Empanelled Hospitals](#)



QUICK LINKS

[Delhi/NCR CGHS Rate List](#)

[CGHS Circular](#)

[Life Saving Drugs List](#)

MEDICAL SECTION

There are three types of claims which received by the Section.

1. Claims received under 'Direct Payment Facility' in which an employee gets the in-patient treatment at the empanelled hospital under cashless facility.
2. Claims received under 'Reimbursement Facility' in which an employee gets the in-patient treatment at the empanelled hospital by paying first and submit the claim for reimbursement.
3. Claims received under 'Out-Patient Deptt.' (OPD) in which an employee gets the OPD treatment from the Authorized Medical Attendance (empanelled Doctors and OPD of empanelled hospitals) by paying themselves and submits the claim for reimbursement.

The following steps are involved in the processing of passing medical reimbursement claims:

- (i) Receipt and diary of medical reimbursement claim.
- (ii) To scrutinize and processing of the claim as per CGHS rules and rates.
- (iii) To raise objection, if any.
- (iv) To pass the claim.
- (v) To send the claim for release of payment to Account Section And;
- (vi) Payment being sent to the respective claimants' savings bank account through ECS/NEFT.

Login User

Medical Card No.

Password

Login

Reset

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Registration Form

Medical Card No.

First Name

Last Name

Gender

Mobile Number

Email-Id

Password

Confirm Password

Register

Reset

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Forget Password Recovery

Mobile

Email ID

Submit

Reset

[» Login User](#)

Personal Information

Name	<input type="text" value="S"/>	Medical Card No.	<input type="text" value="10001"/>
Department	<input type="text" value="Department of Political Science"/>		
Designation	<input type="text" value="Programmer"/>	Pay of the Univ. Emp.	<input type="text" value="15000"/>
Marital Status	<input type="text" value="Married"/>	Where Employed	<input type="text" value="Satyawati"/>
Address	<input type="text" value="North Delhi"/>	Mobile	<input type="text" value="8527609299"/>
Email-Id	<input type="text" value="sanjayperfectmath888@gmail.com"/>	DOB	<input type="text" value="12/05/1988"/>
Date of Retirement/ Date of Death	<input type="text" value="31/10/2029"/>		

Upload Medical Card
 No file chosen
(Only .jpg & File size upto 500kb.)

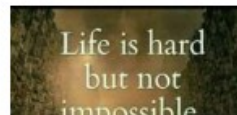
Front Side

Upload Medical Card
 No file chosen
(Only .jpg & File size upto 500kb.)

Back Side



[View Front Side](#)



[View Back Side](#)

Details of Family Member

Name

Medical Card No.

Relationship

DOB (DD/MM/YYYY)

DOB is required

Submit

Reset

FORM OF THE APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES
INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR
TREATMENT OF UNIVERSITY EMPLOYEES AND THEIR FAMILIES

N.B. :Separate Form should be used for each Patient.

1.	Employee Category:	<input type="text" value="Non-Teaching"/>		
2.	Name	<input type="text" value="S"/>	Designation of the Employee :	<input type="text" value="Programmer"/>
	(i) Merital Status.	<input type="text" value="Married"/>		
	(ii) if married, the place where wife/husband of the employee is employed (where applicable) (In case employed , a joint declaration duly countersigned by the wife's/husband's employer may be furnished) at the time of first bill during each financial year.			<input type="text"/>
3.	Where Employed :	<input type="text" value="Department of Political Scie"/>		
4.	Pay of the University/college,Employee and any other emoluments, which should be show separately :	<input type="text" value="15000"/>		
5.	Place of Duty :	<input type="text" value="Ducc"/>		
6.	Actual Residential Address :	<input type="text" value="North Delhi"/>		
7.	Name of the Patient :	<input type="text" value="Self"/>	and his/her relationship : to the University/College employee	<input type="text" value="Employee"/>
	In the case of the children , state age also.	<input type="text" value="12/05/1988"/>		
8.	Place at which the patient fell ill :	<input type="text" value="Home"/>		
9.	Whether member of	<input type="text" value="NO"/>	If,Yes Token No.	

9. **Whether member of W.U.S Health Center :** **If, Yes Token No.**

10. **Medical Treatment as :**

MEDICAL ATTEDANCE / OPD

(i) Name of the Doctor

(ii) Designation of the Doc.

	SNo#	Date	Consultation Fee
(iii) Dates and fee paid for each consultation.	1.	<input type="text" value="02/10/2018"/>	<input type="text" value="150"/>
	2.	<input type="text" value="03/10/2018"/>	<input type="text" value="150"/>
	3.	<input type="text"/>	<input type="text" value="0"/>

(iv) Lab Test Charges

[Details of Labs Test](#)

Name of the hospital or Laboratory where undertaken

(vi) Cost of the Medicines & Other charges

[Details of Medicines](#)

11. **Total amount claimed**

12. **List of enclosure**
- Prescription
 - Bill/Cash Memo/Receipt (In original)
 - Discharge Summary (In case of Hospitalized)
 - Copy of Lab Reports
 - other

DETAILS OF LABORATORY TEST

S#	Name of Lsb Test	Cost	Action
--- Note: Lab test list is Currently Empty. Add Few Lab test ---			
	Select ▼		Add

Save

Discharge Summary (In case of Hospitalized)

Update

Reset

Details of Labs Test

Details of Medicines

DETAILS OF MEDICINES PURCHASED

S#	Name of the Medicines	Quantity	Cost	Action
--- Note: Medicine list is Currently Empty. Add Few Medicines ---				
				Add

Save

Discharge Summary (In case of Hospitalized)

Update

Reset

Details of Labs Test

Details of Medicines

Claim History

Sno#	Claim Form	Claim No.	Member Name	Date of Claim	Total Claim_Amt.	Approved Claim Amt.	Status	Remarks
1	View	100009	Self	10/10/2018	300	300	Approved	Cghs
2	View	100008	Self	10/10/2018	2200	2200	Approved	Cghs
3	View	100007	Self	10/10/2018	150		Pending	
4	View	100002	Self	07/10/2018	2365		Pending	
5	View	100001	Self	25/09/2018	3070	2050	Approved	Approved

View Claim Status

Claim No.

View

Claim Number	Member Name	Date of Claim	Total Claim	Claim Approved	Remarks	Status
100001	Self	25/09/2018	3070	2050	Approved	Approved

Details Approved Amount

Contact US

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