ANNEXURE-I

DELHI POLLUTION CONTROL COMMITTEE EMPLOYEES MEDICAL SCHEME (DEMS)
MODIFIED CHECK LIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. DEMS Card No. and Place of Issue: -

2. Validity of DEMS 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) Medical Form: -

b) Photocopy of DEMS 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 Empaneled /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) If 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

k) 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----------
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Dated:

Signature of DEMS Card Holder

Telephone No. (M)---------- (O)---------- Email 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 claims.

ANNEXURE-II

DELHI POLLUTION CONTROL COMMITTEE EMPLOYEES MEDICAL SCHEME (DEMS)

MEDICAL FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF DEMS BENEFICIARIES

(To be filled by the claimant)

1. DEMS Card No. and Place of issue: -

2. Validity of DEMS 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 statement 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 dependent on me. I am a DEMS beneficiary and the DEMS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Dated:

Signature of DEMS card Holder

Note: Misuse of DEMS facilities is a criminal offense. Suitable action including cancellation of DEMS 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.