ANNEXURE – A

MEDICAL FACILITY FOR BSNL EMPLOYEES
OPTION FORM

1. Name of Employee:

2. Designation:

3. Place of Posting:

4. Options for availing Medical Policy:
   i) CGHS
   ii) BSNLMRS

5. Details of CGHS Card, if any
   i) CGHS Card No.:

I, do, hereby certify that I have gone through the notification of BSNL Medical Reimbursement Scheme and am exercising my option after satisfying myself about various provisions under BSNLMRS.

(Signature of Employee)

ANNEXURE - B

BHARAT SANCHAR NIGAM LTD.

BSNL EMPLOYEES MEDICAL REIMBURSEMENT SCHEME

REGISTRATION FORM

1. Name of Employee: 2. Designation:
3. Place of posting: 4. Staff No.: 5. Basic Pay:
6. Telephone: (Office)------------------- (Residence) -----------------------
7. Details of Family Members:

Sl. No.	Name	Date of Birth	Relationship with employee	Blood Group (If available)

8. Details of chronic disease, if any: a)---------------------
b)---------------------
c)---------------------
d)---------------------
9. Options for outdoor treatment (under BSNLMRS):-
(tick any one of i), ii) or iii))

i) Outdoor/Domiciliary treatment from RMPs: Reimbursement against vouchers (as per Para 2.1.0).

ii) Outdoor/Domiciliary treatment: Entitlement without voucher(as per para 2.1.1)

iii) Outdoor/Domiciliary treatment from P&T Dispensaries (as per Para 2.1.2)

Declaration:

I hereby declare that above mentioned members of my family are fully dependent on me i.e. their income from all sources does not exceed Rs. 1500/- per month. If the above information is found to be false at any time, company can take action against me as per rules or as deemed fit.

(Signature of Employee)

FOR OFFICE USE ONLY

REIGSTRATION NO. ISSUED--------------------
CARD ISSUED : YES/NO on ---------------------
(Date of issue)

Signature of Issuing Authority

ANNEXURE - C

MEDICAL REIMBURSEMENT CLAIM FORM FOR OUTDOOR TREATMENT

1. Name of Employee: 2. Designation:
3. Reg. No.:
4. Salary (Basic Pay + DA)/Pension (as on 01-04--------):
5. Place of Duty: 6. Name of Patient:
7. Relationship with Employee: 8. Age:
9. Reimbursement claimed under:
   (Tick relevant box)
   - Treatment from RMP (as per Para 2.1.0) ☐
   - Treatment from P&T Dispensary (as per Para 2.1.2) ☐
10. Nature of illness:
11. Name of Doctor/Hospital:
12. Details of claim:
   (attach prescription, vouchers, etc. in duplicate)

	Voucher No.	Amount
• Consultation:		
• Diagnostics/Tests:		
• Medicines:		
• Appliances:		
• Special treatment (e.g. Physiotherapy, Yoga etc.):		
• Others:		
Total:		

(Rupees---)

Declaration:

I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is wholly dependent on me.

(Signature of Employee)

ANNEXURE – D

MEDICAL REIMBURSEMENT CLAIM FORM FOR INDOOR TREATMENT

1. Name of Employee:
2. Designation:
3. Reg. No.:
4. Salary (Basic Pay + DA)/Pension (as on 01-04--------):
5. Place of Duty:
6. Name of Patient:
7. Relationship with Employee:
8. Age:
9. Nature of illness:
10. Name of Doctor/Hospital:
11. Period of treatment: From ------------- To--------------------
    (Certificate issued by the Medical Officer in-charge of the hospital as per enclosed proforma is to be attached)
12. Details of claim:
    (attach prescription, vouchers, etc. in duplicate)

	Voucher No.	Amount
• Consultation:		
• Diagnostics/Tests:		
• Medicines/Injections:		
• Appliances:		
• Room Rent:		
• Charges for Nurses:		
• Others:		
	Total:	

(Rupees--)

Declaration:

I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is fully dependent on me.

(Signature of Employee)

Annex. D-I

CERTIFICATE FOR HOSPITALIZATION

(To be completed in the case of patients who are admitted to hospital for treatment)

Certificate granted to Mrs./Mr./Miss ______________________ , husband /wife /son /daughter /mother /father of Mrs/Mr _____________________________ employed in the office of_______________________________,BSNL.

PART `A'

I, Dr. ____ hereby certify:

(a) that the patient was admitted to hospital on ____________________________.

(b) that the patient has been under treatment at _________________and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient.

(c) that the patient is/was suffering from ___________________and is/was under treatment from _________________to ___________________.

(d) that the X-ray, laboratory tests, etc. for which an expenditure of Rs. ___________ was incurred were necessary and were undertaken on my advice at __________________ (name of hospital or laboratory);

Signature and Designation of the
Medical Officer In-charge of the
case at the hospital

ANNEXURE – E

BHARAT SANCHAR NIGAM LTD.

APPLICATION FORM FOR MEDICAL ADVANCE

1. Name of Patient
2. Relationship with Employee:
3. Age:
4. Name of Disease (for which hospitalization is required):
5. Name of Hospital:
6. Name of Employee:
7. Designation:
8. Salary (Basic + DA)/Pension:
9. Basic Pay:
10. Estimated cost of treatment
    (Enclose original copy of hospital's estimate)
11. Amount of Advance required for treatment:

Signature:
Designation:
Section:
Tel. No.:

ANNEXURE - F

Bharat Sanchar Nigam Ltd.
(A Govt. of India Enterprise)
Corporate Office
Statesman House, B-148 Barakhamba Road,
New Delhi - 110 001.

No.
Date:

AUTHORISATION LETTER FOR TREATMENT IN HOSPITAL

This is to certify that Sh./Smt.---(Name of the patient),Age--------------- is the Husband/Wife/Son/Daughter/Mother/Father of Sh./Smt.-----------------------,an employee of BSNL. He/She may be admitted in (Hospital's Name) ---as per his/her room entitlement, i.e. ---.

He/She may be charged as per agreed rates with BSNL.
Bills as per agreed rates may be sent to this office for payment.

(Signature of the Competent Authority)