

NATIONAL GREEN TRIBUNAL MEDICAL FACILITIES SCHEME, 2018.

FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF (NGTMFS) BENEFICIARIES.

Computer No.

(To be filled by the claimant)

1. NGTMFS Token No:

2. Validity of NGTMFS Token Card: from.....to..... & entitlement : Pvt. / Semi Pvt. / General.

3. Full name of the card holder (Block Letters):

4. Full address:

5. Telephone no. (O) (R)

6. E-mail address if, any:

7. Name of the Bank

8. Branch.....SB A/C No.....

9. Name of the patient & relationship with the card holder:

10. Level as per 7th CPC:

11. Name of the Hospital with Address:

(a) OPD treatment and investigations.

(b) Indoor Treatment.

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

Total amount Claimed

(a) OPD Treatment.

(b) Indoor Treatment.

13. Details of Permission:

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

Date:

Signature of NGTMFS card holder

Note: Misuse of NGTMFS is a criminal offence. Suitable action including cancellation of NGTMFS 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.
