Government of West Bengal
Higher Education Department
College Sponsored Branch
Bikash Bhavan, Salt Lake, Kolkata – 700 091

No. 546-Edn (CS)/1M-01/2017 Dated. Kolkata the 8th March. 2019

NOTIFICATION

In partial modification of this department's Notification No. 1020-Edn(CS) dt. 29.08.2018 and No. 01-Edn(CS) dt. 02.01.2019, the Governor is further pleased to lay the following guidelines in respect of modalities of processing of re-imbursement of claims for the medial benefit under ***"West Bengal Health Scheme for the Beneficiaries of Grant-in-aid Colleges and Universities"***:

I. Approval against the claims preferred by the beneficiaries of West Bengal Health Scheme for Grant-in-aided Colleges and Universities :

The concerned authority i.e. Teacher-in-Charge/Vice-Principal/ Registrar/Vice Chancellor of Grant-in-Aid College /University shall approve the claim of the Beneficiary up to the monetary limit specified in G.O. No. 01-Edn(CS)/EII/O/1M-01/2017 dt. 02/01/2019 of Department of Higher Education and for cases beyond the limit, the authority mentioned hereinabove shall forward the claim to DPI/Higher Education Department along with original voucher for necessary approval.

In all cases original vouchers should be kept in the office of the approving authority for audit.

II. Sanctioning Authority of medical reimbursement claim for beneficiaries of Grant-in-aided Colleges and Universities.

State Government Office (herein Higher Education Department/DPI as the case may be) will sanction fund against the approved cases, for all beneficiaries of Grant-in-Aid Colleges/Universities irrespective of any amount of claim.

Sanction Order shall specifically mention the name of individual in whose favour sanction is made.

Once the sanction is accorded by the DPI/HE Department there is no need for further sanction of the same by the college/university authority as the case may be.

III. Allotment of fund in IFMS to DDO from Department/DPI:

After sanctioning of the claim amount by DPI/HE Department, DDO wise fund shall be allotted through e-Bantan Module of IFMS by DPI/HE Department in favour of the concerned DDO of College/University for payment.

IV. TR Form & Voucher for drawal of reimbursement amount by DDO (College/University):

The claim for Medical Benefit shall be drawn in TR Form No. 31 mentioning beneficiary details. No physical voucher is required to be attached at the time of submission of bill to Treasury as per existing provision. Only sanction letter of DPI/HE department shall be submitted to Treasury at the time of drawal of claim. The medical reimbursement claim shall be drawn by DDO of Grant-in-aid College and University under Head of Account. "70-2202-03-104-00-015-Medical Reimbursement for Government-Aided Colleges Teacher -31-02- Other Grants" and "70-2202-03-102-00-026-Medical Reimbursement for State Aided University Teachers -31-02-Other Grants" respectively.

Moreover, the guidelines for settlement of claims shall be followed as per Finance Department (Medical Cell) Memorandum No. 797-F(MED) dt. 31.01.2011 read with Memo No. 3474-F dt. 11.05.2009, as amended from time to time by Finance Department.

List of inadmissible items, viz. Foods, Tonics, Toilets, Medicines etc shall be guided as per Finance Department (Medical Cell) Memorandum No. 6586-F(MED) dt. 29.06.2011, as amended from time to time by Finance Department.

The Forms of enrolment & re-imbursement of claims along with the preseribed format for approval, recommendation and sanctioned of claim are annexed hereto.

1.	Form A	:	Application for Enrolment
2.	Form B	:	Certificate of Enrolment
3.	Form C	:	Application form for settlement of claim for reimbursement.
4.	Form D	:	Essentialitycertificate–cum-statementof expenditure certified by treating specialist.
5.	Form E	:	Checklist for reimbursement of medical claims.
6.	Form P	:	Approval of claim
7.	Form Q	:	Recommendation for approval of claim
8.	Form R	:	Sanction Order

This order is issued with the concurrence of Finance Department vide their U.O. No. Group-T/2018-2019/1491 dt. 05.03.2019.

By order of the Governor,

Joint Secretary

No. 546/1(17)-Edn (CS)/1M-01/2017 Dated. Kolkata the 8th March. 2019

Copy forwarded for information and necessary action to:

1. Accountant General (A&E). West Bengal. Treasury Building. Kolkata.700001.
2. Principal Accountant General (Audit) West Bengal. Treasury Building Kolkata-700001
3. Pay & Accounts Officer. Kolkata Pay & Accounts Office-1. 81/2/2 Phears Lane. Kolkata-700073.
4. Pay & Accounts Officer. Kolkata Pay & Accounts Office-II. Kolkata-700073
5. Pay & Accounts Officer. Kolkata Pay & Accounts Office-III. IB Market' 1st Floor Sector-III. IB Block. Kolkata-700106
6. Finance Department (Medical Cell). Govt of West Bengal.
7. Finance Department (Group-T). Govt of West Bengal.
8. Finance (Budget) Department. Govt of West Bengal.
9. Director of Public Instruction. W.B. Bikash Bhavan. Salt Lake. Kolkata-700091
10. Special Secretary. University Branch of This Department. Bikash Bhavan. Salt Lake. Kolkata-700091.
11. Special Secretary. C.S. Branch of This Department. Bikash Bhavan. Salt Lake. Kolkata-700091.
12. P.S. to Hon'ble MIC.. Department of Higher Education. Govt. of West Bengal. Bikash Bhavan. Salt Lake. Kolkata-700091.
13. P.S. to Hon'ble MOS.. Health and Family welfare Department. Swasthya Bhavan. Govt. of West Bengal. . Salt Lake. Kolkata-700091.
14. P.S. to Additional Chief Secretary of this Department. Bikash Bhavan. Salt Lake. Kolkata-700091.
15. P.S. to Additional Chief Secretary. Health and Family welfare Department. Swasthya Bhavan. Govt. of West Bengal. Kolkata-700091.
16. IT Cell of this department for uploading a copy of this notification in the departmental website.
17. Guard File

Joint Secretary

Annexure to Notification No.546-Edn(CS)/1M-01/2017

dt. 08/03/2019

FORM A

Application for Enrolment

To

The .....(College Authority/University Authority)

I, Shri/Smt .....(designation).....attached to.....(College/University), District..... under Department of Higher Education, Government of West Bengal do hereby opt for coming under the West Bengal Health Scheme for the beneficiaries of Grant-in-aid Colleges and Universities, 2017, with effect from .....

The particulars of the members of my family as defined in the Scheme is as follows:

Name of Employee:	:
Employee HRMS/ Unique ID(if available)	:
Designation	:
Residential address with District name	:
Gender	:
Marital Status	:
Date of joining in College/ University	:
Date of Superannuation	:
Present pay (Band + Grade Pay)	:
DDO Code	:
Mobile No	:
Email ID	:
Voter Card / Aadhaar/VID No.	:
PAN Card No.	:
Details of Family	:

Sl. No.	Name	DOB	Relationship	Identity Proof No.	Monthly income (Rs.)
1					
2					
3					
4					
5					

I do hereby declare that upon enrolment under the above scheme I shall forgo the regular medical allowance drawn by me as part of salary. I shall also abide by the provisions of the West Bengal Health Scheme for the beneficiaries of Grant -in -aid Colleges and Universities, 2017, as may be in force from time to time.

Enclosure: Recent colour Passport size Photograph , Signature /LTI, copy of Identity proof of all eligible beneficiaries.

Signature of the Applicant

FORM B

Certificate of Enrolment

Memo No.....

Date.....

Certified that Shri/Smt .....(Designation) attached to ....

.....(College/University) under Department of Higher Education, has been enrolled under the West Bengal Health Scheme for the beneficiaries of Grant -in -aid Colleges and Universities, 2017 with effect from .....

The particulars of the members of his family as defined in para of the Scheme are as follows :

Name of the Employee :
Employee HRMS/Unique ID (if available) :
Designation :
Residential address with District name :
Date of joining in College/ University :
Date of superannuation :
Present pay (Band + Grade Pay) :
Mobile No :
Email ID :
PAN Card No. :

Details of Family

Beneficiary ID No.	Name	DOB	Relationship	Identity Proof No.	Photo	Signature

Signature of the Head of the Institution / DDO
DDO Code /Designation :

Memo No.....(1/1)

Date.....

Copy forwarded for information and necessary action to :

1. Shri/Smt .....(Designation)

2. The .....(Drawing and Disbursing Officer).

He/she is requested to discontinue the drawal of regular medical allowance in respect of Shri/Smt.....with effect from .....

Signature of the Head of the Institution / DDO
DDO Code /Designation :

FORM C

Application Form for settlement of claim for reimbursement
(To be filled in by the applicant)

To

The .....(College Authority/University Authority)

Sir/Madam,

I, Shri/Smt .....(Designation).....attached to .....(Grant-in-Aid College/University), District..... under Department of Higher Education, Government of West Bengal, do hereby furnish the reimbursement claim coming under the West Bengal Health Scheme for the beneficiaries of Grant -in -aid Colleges and Universities, 2017.

The particulars of the claims are as follows:

1.	Health Scheme Beneficiary ID No. of Employee	:
2.	Full name of the Employee with designation (in Block letters)	:
3.	Full Address :	
	(i) College/University	:
	(ii) Residence	:
4.	Name of the patient	:
5.	Relationship with the Employee	:
5.	Health Scheme Beneficiary ID of patient	:
6.	Pay (Band Pay + Grade Pay)	:
7.	Name of the Hospital with address	:
8.	Total amount claimed : Rs:	
	(a) For OPD treatment	: Rs:
	(b) For Indoor treatment	: Rs:
	(c) For Indoor and Indoor related OPD treatment	: Rs:
9.	Date of Admission .....Date of Discharge.....	
10.	Details of permission (if required)	
11.	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 beneficiary of the West Bengal Health Scheme for the beneficiaries of Grant -in -aid Colleges and Universities, 2017 and the Enrolment Certificate issued under the Scheme was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Date :

Signature of the Employee / Claimant

Relationship with the Employee:

FORM D

Essentiality Certificate-cum-Statement of Expenditure Certified by Treating Specialist

(to be submitted in duplicate)

(Strike out whichever is not applicable)

1. Health Scheme Beneficiary ID of Patient:
2. Name of the patient and relationship with employee:
3. Name of Hospital, address and Code, if any:
4. Whether Hospital is Empanelled under WBHS or Not:
5. Total amount claimed : Rs
.....(Rupees.....) only

(A) For OPD Treatment :

Rs.....(Rupees.....) only

(B) For Only Indoor Treatment:

Rs.....(Rupees.....) only

(C) For Indoor and Indoor related OPD

Rs.....(Rupees.....) only

(A) OPD Treatment Details:

(I) Name of OPD Disease [As mentioned in 6(1) clause of Notification No.1020-Edn(CS) dt 08.03.19] :

(II) Date of OPD consultation:

(III) Total No. of vouchers :

(IV) Amount claimed : Rs:

(Indicate serial number of individual vouchers with name and address of the shops with date against each sub- heading in a separate annexure wherever required)

	Amount Claimed (Rs.)	Amount Admissible (Rs.) [To be filled up by office (College/ University)]
(a) **Consultation fees.** (Specify number of consultations)		
(b) **Cost of pathological and radiological Investigations.** (Give break up in a separate annexure with code no.)		
(c) **Cost of Medicines.** (Give details of purchase in separate annexure)		
(d) **Cost of Consumables.** (Give details of purchase in separate annexure)		
(e) **Miscellaneous (specify)**		
Sectional Total of SL.(A) : Rs:		

(B) Indoor Treatment Details:

(To be marked N.A. wherever necessary)

(Details of Hospital Bill and other vouchers pertaining to the period of indoor treatment)

(a) Period of Bill From _____ To_____

(b)Amount claimed for

i) Package Treatment :

ii) Non-Package Treatment:

(indicate serial number of individual vouchers with name and address of shops with date against each sub- heading in a separate annexure wherever required)

(I) for Package treatment from ____ to ____ : **[Code start with '01']**

(College/University)] Sl. No.	Procedure Name	Procedure Name	Amount Claimed Rs.	Amount Admissible [To be filled up by office Rs.
(1)	(2)	(3)	(4)	(5)
(i)				
(ii)				
(iii)				
(iv)				

Total Rs:

(II) for Non-Package treatment from _____ to _____

	Amount Claimed (Rs.)	Amount Admissible (Rs.) [To be filled up by Office]
(i) **Consultation Fees.** (Specify number of consultations)		
(ii) **Room Rent.**		
Ward : From: To:		
ICU/ICCU/ITU/ PICU/NICU: From: To:		
HDU/SDU/ Burn Unit : From: To:		
CRIB (Critical Ward Bed) From: To:		
(iii) **Cost of pathological and radiological Investigations.** (Give break up in a separate annexure with code no.)		
(iv) **Cost of Medicines.** (Give details of purchase in separate annexure)		
(v) **Cost of Consumables .** (Give details of purchase in separate annexure)		
(vi) **Cost of Implants.**		
(vii) **Artificial Devices.**		
(viii) **Special Nursing** (Give details in Separate annexure)		
(ix) **Miscellaneous (If Any)** (Give details in Separate annexure)		

Total:

Sectional Total of Sl. (B) [(I) + (II)] : Rs.

(C) Indoor Related OPD Treatment (Includes 30 days' prior admission and 30 days after discharge):

(I) Dates of Related OPD consultation:

(II) Total No. of vouchers :

(III) Amount claimed : Rs.

(Indicate serial number of individual vouchers with name and address of the shops with date against each sub- heading in a separate annexure wherever required)

	Amount Claimed (Rs.)	Amount Admissible (Rs.) [To be filled up by office (College/University)
(a) **Consultation fees.** (Specify number of consultations)		
(b) **Cost of pathological and radiological Investigations.** (Give break up in a separate annexure with code no.)		
(c) **Cost of Medicines.** (Give details of purchase in separate annexure)		
(d) **Cost of Consumables.** (Give details of purchase in separate annexure)		
(e) **Miscellaneous (specify)**		
Total (Rs.) :		

Sectional Total of SL.(C) (Rs.) :

Total claim [Either only (A) or (B) or (B) + (C)]

(Signature of Claimant)

Name in Block Letters with Health Scheme beneficiary ID (if available)

Relationship with Employee:

Address :

1. Certified that the relevant bills/vouchers have been verified by me as per latest approved rates of the WBHS. 2008 and the expenditures shown above are correct and the treatment services provided were essential and minimum that required for the recovery of the patient.
2. Certified that the treatment was done in an organization having number of beds _____ and having a License under the West Bengal Clinical Establishment Act and Rules bearing no. _____. The License is valid up to _____.
3. Certified that the patient. Sri/Smt._____ was/ has been suffering from _____as listed in Sl. No._____ of the WBHS OPD.
4. _____ (Name of Specific procedure/Operation) performed was on_____
5. Conservative treatment provided from _____ to _____.
6. Certified that the patient had been admitted/consulted under at _____Hospital/Nursing Home
7. Certified that the relevant bills/vouchers have been verified by me and the expenditure shown is correct and the treatment services provided were essential and minimum that was required for the recovery/stabilization of the patient.

Signature

Medical Superintendent/Administrative officer

Signature of the Treating Specialist with official Seal

..... Hospital

Official Seal

FORM E

Checklist For Reimbursement of Medical Claims

1.Name of Patient (BLOCK Letters)

2.Relationship with employee

3.Health Scheme Beneficiary ID No. of the patient

4. Entitlement Private/Semi-Private

5. Full name of Employee (BLOCK letters)

6.Designation of Employee

7.The following documents are submitted (please tick the relevant column)

a)Photocopy of the Enrolment Certificate	YES/NO
b) Essentiality Certificate	YES/NO
c) Number of original bills	YES/NO
d) Whether original bills/vouchers have been verified	YES/NO
e)Copy of discharge summary	YES/NO
(f)Copy of permission letter	YES/NO
(g) Whether the hospital has given break up for lab investigations	YES/NO

(i) In case of Original papers have been lost the following documents are submitted

(I) Photocopies of claim paper	YES/NO
(II) Affidavit on stamp paper	YES NO

(ii) In case of death of Employee the following documents are submitted:

(I) Affidavit on stamp paper by claimant	YES NO
(II) No objection from other legal heirs on stamp papers	YES NO
(III) Copy of death certificate	YES NO

Dated.....

Signature of the Applicant

Relationship with Employee

FORM-P

Name of the Office-
Office Address-

No. Date:

To,
1) Additional Chief Secretary/Principal Secretary/ Secretary/ Joint Secretary
2) Director, Directorate of Public Instruction
Higher Education Department, Government of West Bengal
3) Vice Chancellor,.....University

Sir/Madam,

Approval of claim

A sum of Rs. _____ (in words & Numeric figure) is hereby approved against the reimbursement claim of Shri/Smt _____ , Designation---------- for medical treatment of .....(Beneficiary Name and ID No) at _____(Name of Hospital) during the Period from DD/MM/YYYY to DD/MM/YYYY.

It is certified that all the submitted original bills/vouchers have been checked & cancelled and retained in my office while approving the claim. And the rate of every item is allowed as per scheduled of rates of the health scheme.

The approved amount may be sanctioned in favour of the above referred beneficiary under the Head of Account ***70-2202-03-102-00-015-31-02-V/ 70-2202-03-102-00-026-31-02-V*** and allotment may be given in favour of the DDO Code _____ for payment of the admissible amount of medical reimbursement.

The amount shall be payable to the Shri/Smt. _____ (Name of the Claimant) / (Name of Spouse/Family Member in case where the employee is already deceased).

Sd/-
Signature of the Approving Authority
Designation:

No. (1/4) Date:

Copy forwarded for information to:-

1. Shri/Smt. _____ (Name of the Claimant) / (Name of Spouse/Family Member in case where the employee is already deceased).
2. Personal File of Shri/Smt. _____.
3. Accounts Section
4.

Sd/-
Signature of the Approving Authority
Designation:

FORM-Q

Name of the Office-
Office Address-

No. Date:

To,
1) Additional Chief Secretary/Principal Secretary/ Secretary/ Joint Secretary
2) Director, Directorate of Public Instruction
Higher Education Department, Government of West Bengal
3) Vice Chancellor,.....University

Sir/Madam,

Recommendation for Approval of claim

A sum of Rs._____ _____ _ (in words & Numeric figure) is hereby forwarded for approval against the reimbursement claim of Shri/Smt_____ _____ _____ _, Designation---------- for medical treatment of .....(Beneficiary Name and ID No) at _____ ____(Name of Hospital) during the Period from DD/MM/YYYY to DD/MM/YYYY.

It is certified that all the submitted original bills/ vouchers are checked and rates claimed in bills are corrected/ modified as per schedule of approved rates. The eligible consolidated claim is forwarded along with original vouchers / bills for according necessary approval as per existing Government Order.

The approved amount may be sanctioned in favour of the above referred beneficiary under the Head of Account ***70-2202-03-102-00-015-31-02-V/ 70-2202-03-102-00-026-31-02-V*** and allotment may be given in favour of the DDO Code _____ _____ _____ for payment of the admissible amount of medical reimbursement.

The amount shall be payable to the Shri/Smt. _____ _____ _____ (Name of the Claimant) / (Name of Spouse/Family Member in case where the employee is already deceased).

Sd/-
Signature of the Approving Authority
Designation:

No. (1/4) Date:

Copy forwarded for information to:-

1. Shri/Smt. _____ _____ _____ (Name of the Claimant) / (Name of Spouse/Family Member in case where the employee is already deceased).
2. Personal File of Shri/Smt. _____ _____ _____.
3. Accounts Section
4.

Sd/-
Signature of the Approving Authority
Designation:

FORM-R

Government of West Bengal
Name of the Office----------
Office Address: .....

No. Date:

SANCTION ORDER

Sanction is hereby accorded for the total amount of Rs. _____ (in words & Numeric figure) in favour of following beneficiaries against the approved medical reimbursement claim.

The sanctioned amount will be drawn by the [Name of institute] from the Treasury/PAO to which the drawing officer of the institute attached in TR Form No.- 31 for medical treatment of following beneficiaries.

Sl. No.	Application No.	Name of the employee	Employee WBHS ID	Patient Beneficiary Name	Patient WBHS ID	Amount (Rs.)
			Total			

The Amount is chargeable under the head of account ***70-2202-03-102-00-015-31-02-V/ 70-2202-03-102-00-026-31-02-V*** from the budget provision of the financial year----------.

No utilisation is required to be submitted for the grant sanctioned in favour of beneficiary against the claim of medical reimbursement.

Payment shall be made to the Claimant directly into the Bank Account in terms of G.O No. _____ dated _____ of Higher Education Department accompanying the copy of Sanction order with the bill.

Sd/-
Signature of the Approving Authority
Designation:

Memo No. (1/7) Date:

Copy forwarded for information to:-

1. Principal Accountant General (A&E), West Bengal, Kolkata-700001
2. Treasury Officer/Pay & Accounts Officer, _____
3. .....(Sub-Allotting Officer) for sub allotment of fund to DDO in E-Bantan of IFMS.
4. Vice Chancellor / Principal.....University / College
5. DDO of ..... University /College
6. Shri/Smt. _____ (Name of the Claimant) /(Name of Spouse/Family Member in case where the employee is already deceased)
7.

Sd/-
Signature of the Sanctioning Authority
Designation: