पूर्वोत्तर डंदिरा गांधी क्षेत्रीय स्वास्थ एवं आयुर्विज्ञान संस्थान, शिलांग
NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES, SHILLONG
(भारत सरकार, स्वास्थ्य एवं परिवार कल्याण मंत्रालय, स्वायत संस्थान)
(An Autonomous Institute, Ministry of Health and Family Welfare, Government of India)
निदेशक ब्लॉक, मावडीयांगडीयांग, शिलांग - 793018 मेघालय
Director's Block, Mawdiangdiang, Shillong - 793018 Meghalaya
E-mail- info.neigrihms@nic.in
dda-office@neigrihms.gov.in
www.neigrihms.gov.in
EPABX: (0364) 2538025

NOTIFICATION

F. No. ESTT-I/5/2026-Estt.I Dated: ____/Nov/2026

Subject: Implementation of Employee Health Scheme (EHS) at NEIGRIHMS, Shillong – reg.

Attention is invited to Institute's Notification of even number Dated 7.10.2026, whereby, the Institute had notified the implementation of the Employee Health Scheme (EHS) as per the provisions, terms and conditions contained in the approved EHS Policy Document.

Therefore, all eligible employees of the Institute as per EHS Policy Document including Resident-Doctors/Employees who join on deputation/ Retired employees of the Institute are required to fill up their details in the prescribed Application format placed in the attachment (Annexure A) for Admission to the Scheme and to submit the same with requisite supporting documents for verification to Establishment I section for benefits of Medical Entitlement of EHS Beneficiary for OPD treatment, IPD treatment etc as envisaged in the Scheme.

Digitally signed by
David Teirylang Umdor
Date: 09-11-2026
13:02:02

(Shri D.T.Umdor),
Deputy Director (Admn) I/c

F. No. ESTT-I/5/2026-Estt.I Dated: ____/Nov/2026

Copy for information with a request to circulate the above contents amongst the Faculty, Officers, and Staff working under their charge to:

1. Dean/Medical Superintendent, NEIGRIHMS, Shillong.
2. All Heads of Departments/Sections, NEIGRIHMS.
3. Accounts Officer, NEIGRIHMS for necessary action.
4. Administrative Officer, Establishment-I Section, NEIGRIHMS for necessary action.
5. Programmer, IT Cell, NEIGRIHMS for uploading in the Institute's website.
6. Medical Record Officer, NEIGRIHMS for necessary action.
7. The Dealing Assistant, Medical Declaration of Family Dependants for information and necessary action.
8. The Dealing Assistant, Pension for information of the retired employees of the Institute.
9. PA to the Director for information of Director.

Sd/-
(Shri D.T.Umdor),
Deputy Director (Admn) I/c

Annexure 'A'

APLLICATION FOR EMPLOYEE HEALTH SCHEME

Please tick (✓) which is applicable and strike out of (×) whichever not applicable

1. Name of the applicant .....

2. Category: Please tick (✓) whichever is appropriate

a) Service Employee: Regular ☐ / Adhoc ☐ / Temporary status ☐

/ on deputation ☐

b) Resident: Senior Resident ☐

3. Designation: ..... Name of the Department:

.....

4. Basic pay: .....Blood Group:

.....

5. Office Address:

.....

.....

6. Permanent Address: .....

.....

7. Mobile Number: ..... Emergency Contact No: .....

8. E-mail address: ..... Date of Birth: .....

9. Date of Joining: ☐☐ ☐☐ ☐☐☐☐

D / D M / M Y / Y /Y/ Y

10. Date of superannuation (in case of serving NEIGRIHMS employee)

☐☐ ☐☐ ☐☐☐☐

D / D M / M Y/ Y / Y/ Y

11. Date of superannuation (in case of serving NEIGRIHMS employee)

D	/	D		M	/	M	Y / Y / Y / Y	

12. Details of dependent (including self)

(*Please see definition of family in the instructions before filling up this Column)

Sl. No	Name of family member & dependent	Relationship with Employee	Date of Birth	Gender	Blood Group	Marital Status	Mobile No.	Email ID	(Validity to be filled by Concerned establishment Section)

13. Are all the persons whose names are given above are dependent upon you?

Yes ☐ No ☐

a. Please attach proof of their relationship with you, like copy of Ration Card / Aadhaar card/Election Card/ Passport/Identity Card issued by college/ School University/Bank passbook etc.

b. Please attach proof of dependency in respect of age of son(s) & daughter(s) with reference to dependency criteria attached herewith as mentioned in the instructions.

14. Paste one Photograph of each member of dependent Family members including self.

Name:	Name:	Name:	Name: .....
Sign:	Sign:	Sign:	Sign:
Name:	Name:	Name:	Name: .....
Sign:	Sign:	Sign:	Sign:

a. I certify that my family members as above are wholly dependent on me.

b. I undertake to intimate immediately if there is any change in dependency criteria of my family members included in this application form. If I fail to intimate and if the authorities come to know of the same, then the E.H.S. facility is liable to be withdrawn by NEIGRIHMS and appropriate authority will be free to initiate any action against me.

c. I undertake to surrender the EHS card(s) on my leaving the NEIGRIHMS, Shillong on completion of tenure/ retirement/termination/ resignation or on ceasing to be eligible of EHS benefits.

d. I certify that the information furnished by me in this application has been verified to be correct and that no information has been concealed or has been misrepresented and I stand by the same.

(Signature of applicant)

Date:

Place:

(Forwarded by Head of Dept / Section)

(Signature of Head of Dept / Section)

Date:

Place:

DECLARATION

1. I hereby declare that my father /mother/ father-in-law/ mother-in-law namely .....is /are wholly dependent upon me and that he/she/they normally reside with me at Shillong.

2. I also certify that my father namely ..... and mother namely .....are dependent on me and their income from all sources including Pension/Family pension and Pension equivalent of DCRG does not exceed Rs.9000+DR per month plus the amount of Dearness Relief there on.
3. I certify that my son ..... Age.....years is unmarried/unemployed and wholly dependent on me.
4. I certify that my daughter ..... Age.....years is unmarried/unemployed and wholly dependent on me.
5. I undertake to surrender the E.H.S. Card on my leaving the Institute on completion of tenure/ retirement/ termination of service, resignation etc.

(Signature of applicant)

Date:

Place:

(TO BE VERIFIED BY THE CONCERNED ESTABLISHMENT SECTION)

1. The information furnished by the applicant has been verified from his service records and found to be correct. It is recommended that a E.H.S No ..... to be issued to Mr /Ms. / Dr. ..... Designation..... who is working in Department/Section.....
2. Finance division NEIGRIHMS has been intimated about required deduction towards of the E.H.S. subscription every month from the salary of the applicant.
3. It is requested to consider for the issue of New E.H.S. photo Cards to the beneficiary / beneficiaries as per E.H.S. token card.

Signature of the authorized signatory with seal

Date:

Place:

(To be filled in by the E.H.S. Cell)

E.H.S No:_____has been allotted to the applicant by the E.H.S. Cell.

Signature of the authorized signatory with seal

Date:

Place:

INSTRUCTIONS

Definition of Family: The term 'family' shall mean beneficiary's spouse, children (including legally adopted children, children taken as wards & stepchildren), parents, divorced/ abandoned/ or separated from their husband/widowed daughters and unmarried/ divorced / abandoned or separated from their husband / widowed sisters, brothers & stepmother wholly dependent upon the beneficiary and normally residing with the beneficiary or in a station other than the beneficiary's headquarter. Age-limits of dependent son/daughter for the purpose of availing medical facilities is as indicated below (as per CGHS guidelines):

(i)	Son	Till he starts earning or attains the age of 25 years or gets married, whichever is earlier
(ii)	Daughter	Till she starts earning or gets married, irrespective of the age limit, whichever is earlier.
(iii)	Son suffering from any permanent disability of any kind (physical or mental)	Irrespective of age-limit
(iv)	Dependent divorced abandoned or separated from their husband/ widowed daughters and dependent married divorced abandoned or separated their husband widowed sisters.	Irrespective of age-limit
(v)	Minor brother(s)	Up to the age of becoming a major

For the purpose of availing EHS facility for disabled sons above 25 years, please attach a copy of the certificate of disability issued by the competent authority.

The Following Documents are to be enclosed:

1. Proof of Residence/Stay of dependents-(copy of Ration Card/ Adhaar card Election Card/ Passport Identity Card issued by college/ School University/Bank pass book etc...
2. Proof of age of son
3. Attested Copy of Disability certificate issued by Competent Authority (in case of dependent son aged 25 and above)

Annexure 'B'

NON-AVAILABILITY CERTIFICATE

(on the letter head of the authorized pharmacy)

This is to certify that the following medicine (s) prescribed is/are not available at the Institute's Pharmacy as on_____(date):

1.

2.

3.

4.

5.

6.

For_____(Name of the Authorized Official)

Signature of the authorized signatory with seal

Date:

Place:

Annexure 'C'

EMPLOYEE HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the EHS Card holder in BLOCK LETTERS)

1. (a) Name of the EHS card Holder:

   (b) EHS Card Number:

   (c) Employee Code Number:

   (d) Ward Entitlement: Pvt./Semi-Pvt./General

   (e) Full Address:

   (f) Mobile telephone number and e-mail:

2. (a) Patient 'name:

   (b) Patient's EHS Number:

   (c) Relationship with the EHS Card holder:

3. Name & address of the hospital/diagnostic centre/Imaging centre:

4. Whether the hospital/diagnostic/ imaging centre is empanelled under EHS/CGHS: Yes/No

5. Treatment for which reimbursement claimed:

(a) OPD Treatment / Test & investigations

(b) Indoor Treatment

6. Whether treatment was taken in emergency: Yes/No

7. Whether prior permission was taken for the treatment: Yes/No

8. Whether subscribing to any health/medical insurance scheme: Yes/No

if yes amount claimed/received

9. Details of Medical Advance taken, if any:

10. Total amount Claimed:

(a) OPD Treatment:

(b) Indoor treatment:

(c) Test/Investigation:

11. Name of the Bank .....

A/C Number..... Branch MICR Code:.....IFSC Code.....

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 an EHS beneficiary and the EHS card was valid at the time of treatment. My monthly EHS contribution is deducted from my salary. I agree to the reimbursement as is admissible under the rules.

Signature of the EHS Card Holder

Date:

Place:

Annexure 'D'

ESSENTIALITY CERTIFICATE

CERTIFICATE 'A'

(To be completed in the case of patients **WHO ARE NOT ADMITTED** to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss.....wife/son/daughter of Mr./Mrs/Miss..... employed in the .....

I Dr .....hereby certify:

(a) that I charged and received Rs.....for consultation on (dates to be given) at my consulting room at the residence of the patient.

(b) that I charged and received Rs..... for administering..... intravenous / intra-muscular/ subcutaneous injections on.....(Dates to be given) at .....my consulting Room/the residence of the patient.

(c) that the injections administered were not/were for immunizing or prophylactic purposes.

(d) that the patient has been under treatment at ..... hospital / my consulting room 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. The medicines are not stocked in the..... (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Sl. No.	Name of medicine	Price (INR)

(e) that the patient is/was suffering from ..... and is/was under my treatment from.....to.....

(f) that the patient is /was not given pre-natal or post-natal treatment.

(g) that the X-ray laboratory test etc. for which an expenditure of INR..... was incurred on undertaken was necessary and were undertaken on my advice at ..... (name of the hospital or laboratory).

(h) that I referred the patient to Dr ..... and that the necessary approval of the..... (Nam of the Chief Administrative Officer of the State) as required under the rules was obtained;

(i) that the patient did not require/required hospitalization.

Signature of AMA/Designation of the
Medical officer and hospital/ dispensary
to which attached.

Date:

Place:

N.B.: certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by the medical officer in all cases.

ESSENTIALITY CERTIFICATE

CERTIFICATE 'B'

(To be completed in the case of patients **WHO ARE ADMITTED** to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss.....wife/son/daughter of Mr./Mrs/Miss..... .....employed at .....

PART-A

1. Dr .....hereby certify:

(a) That the patient was admitted to hospital on the advice of officer/on my advice of..... .....(name of the medical officer) / on my advice:

(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. The medicines are not stocked in the..... (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

Sl. No.	Name of medicine	Price (INR)

(c) that the injections administered were / were not for Immunizing for prophylactic purposes.

(d) that the patient is/was suffering from ..... and is / was under treatment from.....to .....

(e) that the X-ray, laboratory test etc. for which an expenditure of INR.....was incurred were necessary and were undertaken on my advice (name of hospital or laboratory):

(f) that I called on Dr..... for specialist consultation and that the necessary approval of the.....(Name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.

Signature and Designation of the

Medical Officer-in-charge of the case at the hospital.

Date:

Place:

PART B

Certify that the patient has been under treatment at the..... hospital and that the service of the special nurses for which an expenditure of ₹.....was incurred, vide hills and receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature and Designation of the

Medical Officer-in-charge of the case at the hospital.

Date:

Place:

COUNTERSIGNED

*I certify that the patient has been under treatment at the.....Hospital and the facilities provide were the minimum which were essential for the patient's treatment.

Medical Superintendent

..... Hospital

Date:

Place:

NOTE: CERTIFICATES NOT APPLICABLE SHOULD BE STRUCK OFF. CERTIFICATE (B) IS COMPULSORY AND MUST BE FILLED IN BY THE MEDICAL OFFICER IN ALL CASES.

Annexure 'E'

Document Checklist for Medical Reimbursement through EHS

Sl. No.	Details of the Document submitted	Yes/No	Page No.
1	EHS Number		
2	Self -Explanatory letter form beneficiary Explaining emergency circumstances		
3	Application for MRC		
4	Non-Availability Certificate (if applicable)		
5	Copies of all the prescription		
6	Essentiality certificate		
7	Copy of referral		
8	A copy of discharge summary attached in case of IPD treatment		
9	Original Bills Attested both by consultant & EHS beneficiary		
10	List of all medicines, Laboratory tests investigations.		
11	Permission copy of Medical Board/Director NEIGRIHMS, Shillong (if applicable)/ Intimation copy to EHS during emergency for approval of treatment outside NEIGRIHMS, Shillong.		
12	Photocopies of claim papers and an affidavit on stamp paper in case original papers have been lost.		

13	Affidavit on Stamp Paper for claiming medical reimbursement, No objection certificate from legal heirs of the beneficiaries & Death Certificate for claim in case of death of the beneficiary.		
14	Bank Details (Salary Account Details) number only		

Annexure 'F'

Proforma for Affidavit for Duplicate Claim Paper Bills on Stamp Paper

.....son/wife/daughter of.....and resident of .....have lost/misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim paper from any source and that the original papers are traced. I shall not stake claim against original bills in future and that in the event I receive any cheque againstthe original bills in future, I shall return the same to competent authority.

Signature of the EHS Card Holder

Date:

Place:

Verified by Notary

INTER - DEPARTMENTAL NOTE (IDN)
ESTABLISHMENT SECTION – II

ID Note No. EST-II-EHS/1/2025-Estt-II
Dated 21st July 2026

Sub: Employee Health Scheme (EHS) Document of NEIGRIHMS Shillong- regarding

I am directed to enclose herewith the Ministry's letter F. No. U.12012/47/2024-H-III [FTS-829655s] dated 10.06.2026 received from U/S Hospital Section-III, MoH&FW, conveying the approval of the Hon'ble HFM, in his capacity as President, Governing Council for implementation of the contributory Employee Health Scheme (EHS) at NEIGRIHMS, Shillong, as per the enclosed EHS document.

This is for favour of information and further necessary action at your end.

This issues with the approval of the Competent Authority, NEIGRIHMS.

Encl. As Above.

Digitally signed by
MORGAN MYLLIEMNGAP
Date: 21-07-2026
10:13:29

Assistant Registrar
Establishment-II Section &
Academics

To,

Administrative Officer,
Establishment-I Section,
NEIGRIHMS, Shillong.

F. No. U.12012/47/2024-H-III [FTS- 8296555]
भारत सरकार / **Government of India**
स्वास्थ्य और परिवार कल्याण मंत्रालय / **Ministry of Health and Family Welfare**
स्वास्थ्य और परिवार कल्याण विभाग / **Department of Health and Family Welfare**
(अस्पताल-III अनुभाग) / **Hospital-III Section**
****

Kartavya Bhavan-1, New Delhi
Dated: 10th June, 2026

To

The Director,
NEIGRIHMS,
Shillong, Meghalaya-793018

Subject: Employee Health Scheme (EHS) Document of NEIGRIHMS Shillong-reg.

Sir,

I am directed to refer to your letter No. NEIGR-E.II/31/2019/Pt.I dated 13.09.2024 on the subject cited above and to convey the approval of Hon'ble HFM, in his capacity as President of the Governing Council (GC), for implementation of the contributory Employee Health Scheme (EHS) at NEIGRIHMS, Shillong, as per the enclosed EHS document.

2. This should be placed before the Governing Council for ratification in its next meeting.

3. This issues with the approval of the competent authority, MoHFW.

Yours faithfully,

Encl.: A/a.

Digitally signed by
ANURAG TIWARI
Date: 10-06-2026
18:10:02

(Anurag Tiwari)
Under Secretary to the Govt. of India
☏ : 011- 2401 3282

EMPLOYEE HEALTH SCHEME (EHS) FOR NEIGRIHMS, SHILLONG

POLICY DOCUMENT

1. Background

The 5th SFC recommended that serving employees should be entitled to medical treatment and reimbursement which was approved by the 4th Governing Council. However, retired employees have not been extended the same benefits & they currently receive a fixed medical allowance of INR 1000 (Rupees One Thousand only) per month. 40th SFC proposed that the retired employees should be given the same medical treatment and reimbursement benefits as serving employees. However, it was decided by the MoHFW, GoI, after examination of the proposal that it was not feasible, as NEIGRIHMS serving employees are not entitled to the CGHS facility. Further, in pursuance of the suggestions of the 3rd EC, the Institute prepared a draft EHS document for medical treatment and reimbursement for retired employees on the lines of the Employee Health Scheme of AIIMS, New Delhi.

2. Purpose: The purpose of this document is to prescribe procedures and guidelines for the Employee Health Scheme (EHS) of NEIGRIHMS, Shillong.

3. Eligibility criteria for the beneficiaries.

a. The scheme shall apply to all:

i. Regular employees of NEIGRIHMS, Shillong, and their dependent family members.

ii. Retired employees of NEIGRIHMS, Shillong and their dependent family members.

iii. Employees of Central/State Government, Central/State Autonomous bodies, on deputation to NEIGRIHMS, Shillong and their dependent family members till the duration of their deputation.

iv. Resident doctors (SRDs & JRDs) employed under the 'Residency scheme' of the Government of India, and their dependents during the period of their tenure.

v. Special cases under old and new pension wherever disability and/or family pension is eligible.

vi. Ad-hoc faculty and resident doctors

vii. Employee (s) who join on deputation or tenure appointment in the Institute and are willing to opt for subscription to EHS post completion of their tenure, with an affidavit that they have not subscribed to any other health insurance scheme of any other central / state government office/autonomous bodies.

b. ***The scheme shall <u>NOT</u> apply to***:

i. Contractual and outsourced workforce.

ii. Persons working on research projects and related schemes.

4. Family and Dependents

a. The term 'family' shall mean beneficiary's spouse, children (including legally adopted children, children taken as wards & stepchildren), parents, divorced/ abandoned/ or separated from their husband/widowed daughters and unmarried/ divorced/abandoned or separated from their husband/widowed sisters, brothers & stepmother, wholly dependent upon the beneficiary and normally residing with the beneficiary or in a station other than the beneficiary's headquarter.

b. The income limit for dependency of the family members (other than spouse) is Rs. 9,000/- plus the amount of Dearness Relief admissible on Rs. 9,000/- on the date of consideration of the claim (vide MoHFW, GoI, Office Memorandum No. S-11012/2/2016-CGHS-P dated 08-11-2016). This ceiling of Rs. 9,000/-

p.m. is subject to revision as may be notified by the Government of India from time to time and that such revision shall be effective from the date of notification by the Government of India.

c. Both male & female employee has a choice to include either her dependent parents or her dependent parents-in law. The option exercised can be changed only once during service.

d. Age-limit of dependent sons/daughters for the purpose of availing medical facilities is as indicated below:

Relationship of the family member with the employee	Family member will be considered as dependent on the employee
Son	till he starts earning/attains the age of 25 years/gets married, whichever is earlier. Note: An **'unmarried'** son of an employee suffering from permanent disability of any kind (physical or mental) will be entitled to EHS facility even after attaining the age of 25 years. (Ref: MoHFW OM No. 4-24/96-C&P/CGHS(P)/EHS dated 07.05.2018)
Daughter	she starts earning/gets married, irrespective of her age, whichever is earlier.
Son with permanent disability of any kind	irrespective of his age limit.

Dependent divorced/ abandoned/ or separated from their husband/widowed daughters and dependent unmarried/ divorced/abandoned or separated from their husband/widowed sisters	irrespective of their age limit.
Minor brother(s)	up to the age of becoming a major.

Note: When both husband and wife are employed, the declaration for family and dependents shall be as per Central Services (Medical Attendance) Rules, 1944.

5. Contribution to the scheme:

Beneficiaries shall make a monthly contribution to the scheme which will be deducted from their salary. The monthly deduction will be based on the pay levels, as per 7th CPC, the details of which are mentioned below (Ref: MoHFW, GoI, Office Memorandum No. S-11011/11/2016-CGHS-P/EHS dated 09-01-2017):

Sl. No	Levels in the pay matrix	Monthly contribution (INR)
1.	Levels 1-5	250.00
2.	Level 6	450.00
3.	Levels 7-11	650.00
4.	Level 12 and above	1000.00

Employees / Pensioners* may avail of the EHS facility as per qualifying criteria given below:

(a) Eligible ex-employee (who had retired by taking VRS or on Superannuation before the introduction of the EHS facility): lump sum amount (equivalent to 10 years contribution, as per the level in the 7th CPC pay matrix mentioned in the table above).

(b) Upon retirement (in accordance with the Pension Rules) employees who had previously subscribed to EHS, will have to pay a lump sum amount (10 years contribution) as per the level in the 7th CPC pay matrix mentioned in the table above.

(c) Contribution to be made by the pensioner/family pensioners would be the amount that they were subscribing at the time of their retirement or at the time of death of the beneficiary.

(d) Payment of additional amount as a result of any revision in the rates of contribution, as and when notified, will apply to all beneficiaries (except to those who make 10 years lump sum contribution) as in Sl. No. 1 and 2 of table regarding contribution to the scheme.

6. **Admission to the Scheme:**

Eligible beneficiaries will be required to fill out an Application (Annexure 'A') for enrolling in the scheme and submit the same with requisite supporting documents for verification.

7. **Issue of EHS/Health Card:**

After verification, eligible beneficiaries will be issued an EHS Identity card (beneficiary and eligible dependents). The card will have to mandatorily be provided/used by the beneficiary to avail of facilities available at NEIGRIHMS, Shillong, as per their entitlement including OPD consultation, IPD treatment, laboratory, and radiological investigations etc. free of charge.

MEDICAL ENTITLEMENT OF EHS BENEFICIARY

8. **Treatment at NEIGRIHMS, Shillong:**

(a) **OPD Treatment**

(i) **OPD services** for necessary consultation/examination in the OPD of NEIGRIHMS, Shillong.

(ii) **Investigations and Treatment Procedures:** Diagnostic tests and treatment procedures as advised by the consultants and which are available at NEIGRIHMS, Shillong, will be free of charge for beneficiaries. For any test that is not available at NEIGRIHMS (certified by the MS), the beneficiary will be referred to another centre and the amount will be reimbursed as per rules and CGHS rates or actuals, whichever is lower.

(iii) **Purchase of prescribed medicine:** Beneficiary may procure all prescribed medicines from the market till such time that the NEIGRIHMS pharmacy is made operational. Once the NEIGRIHMS pharmacy is operational, the beneficiary will be bound to take the prescribed medicines from the NEIGRIHMS pharmacy. In case the medicine/s prescribed by the consultant/specialist, is/are not available in the NEIGRIHMS pharmacy, the same will be procured andprovided to the beneficiary by the NEIGRIHMS Pharmacy. In case of emergency, the beneficiary may be advised to procure the same from the market and seek reimbursement as per rules. A "Non-Availability Certificate" (Annexure 'B') issued by the NEIGRIHMS Pharmacy / NEIGRIHMS stores willhave to be provided by the beneficiary for processing the reimbursement.

(b) IPD Treatment

(i) **Ward Entitlement:** Type of ward / room allotted in the hospital will depend upon the basic pay drawn by the employee as per 7th CPC. The entitlement of the ward will be as under:

Sl. No.	Corresponding Basic Pay drawn by Officer in 7th CPC per month	Entitlement
1	Upto Rs. 36,500/-	General Ward
2	Upto Rs. 36,500 to Rs. 50,500/-	Semi-Private
3	Above Rs. 50,500/-	Private Ward

(iv) **Procurement of Drugs/Consumables/Surgical Items:** Beneficiary may procure all prescribed medicines / consumables / surgical items from the market till such time that the NEIGRIHMS pharmacy is made operational. Once the NEIGRIHMS pharmacy is operational, the same will be arranged from the NEIGRIHMS pharmacy to the beneficiary. If any of the required items are not available in the NEIGRIHMS Pharmacy, the same will be procured and provided to the beneficiary by the NEIGRIHMS Pharmacy. In case of emergency, the beneficiary may be advised to procure the same from the market and seek reimbursement as per rules. A "Non-Availability Certificate" (Annexure 'B') issued by the NEIGRIHMS Pharmacy will have to be provided by the beneficiary for processing the reimbursement.

9. **Treatment at places other than NEIGRIHMS, Shillong:** If a beneficiary avails of medical facilities in places other than NEIGRIHMS, Shillong, the Central Services (Medical Attendance) Rules, 1944 as amended from time to time, shall apply.

(a) **Referral by NEIGRIHMS, Shillong to other hospitals:** If the Consultant/Specialist at NEIGRIHMS, Shillong is of the opinion that a beneficiary should receive medical treatment at another hospital, either due to the non-availability of a particular treatment/procedure/facility in the institute or due to the serious or special nature of the illness, consultant may, with the approval of the Medical Board (mandatory requirement unless the delay would endanger the patient's health), refer the patient to the nearest government/CGHS empanelled private hospital where the particular treatment / procedure / facility is available for consultation or further care. In certain cases, the Medical Board may approve referral to government/CGHS empanelled private hospital other than nearest government/CGHS empanelled private hospital on case-to-case basis, subject to the approval by the Competent

Authority. The expenses incurred will be reimbursed as per CGHS rates or actuals, whichever is lower.

(b) **Travelling allowance:** If a beneficiary is referred to the government/CGHS empanelled private hospital, as per Sl. No. 9(a), they will be entitled to travel allowance for the journey to and from the referred hospital, as per the Central Service (Medical Attendance) Rules, 1944. To claim this allowance, the beneficiary must produce a certificate in writing from the consultant.

(c) **Purchase of prescribed medicine:** If a beneficiary attends a nearest government/CGHS empanelled private hospital as an OPD patient after being referred by the consultant/specialist at NEIGRIHMS, Shillong and gets the prescription for medicines, the same may be procured from any pharmacy, however, the reimbursements will be as per CGHS rates or actuals, whichever is lower.

(d) **Investigations:** Tests and investigations advised at the referred hospital should preferably be done there. However, if it is not feasible or the facility is not available at the referred hospital, the tests and investigations can be availed at any other hospitals, laboratories, or imaging centres but it shall be reimbursed as per CGHS rates or actual, whichever is lower.

(e) **Treatment Procedures:** In the case of elective planned medical treatment procedures, beneficiaries can avail medical treatment from referred nearest government/CGHS empanelled hospital. They will be reimbursed as per CGHS rates or actuals, whichever is lower. The referral should be only for services or facilities not available at NEIGRIHMS, Shillong. Under special circumstances, and with prior permission from the competent authority, reimbursement may be made for unlisted investigations, treatment, and procedures, referral treatments, etc. Ex-post facto sanction can be granted only in exceptional and

extremely deserving cases. The following documents are required to be submitted for permission:

- Request letter to give permission, from employee clearly mentioning the name of the unlisted investigations/treatment/procedure and the name of the empanelled hospital where he intends to avail the facility.
- Authorized Medical attendant/Government specialist advise clearly mentioning said investigations/treatment/procedure. Vague advice like advised surgery without mentioning the actual procedure is not acceptable.
- One estimate from empanelled hospital where patient intends to take treatment.
- Other relevant medical documents in support of beneficiary illness.

10. **Special situations when NEIGRIHMS referral is not required:** A serving beneficiary who is out of station on official duty/leave or a retired beneficiary who does not reside in Shillong, Meghalaya can avail medical facilities, including specialist consultation, tests and investigations, indoor medical care, and treatment procedures in any nearest government (like AIIMS, PGIMER etc.) or CGHS empaneled private hospital in that city without a referral from consultant / specialist at NEIGRIHMS, Shillong. Reimbursement in such cases will be made as per CGHS rates or actuals, whichever is lower.

11. **Treatment in Emergency:** In emergency situations, beneficiaries can go directly to any government or CGHS empaneled hospital near their residence or place of illness without a formal referral from NEIGRIHMS. Treatment in private hospitals that are not empaneled under the CGHS near the place of illness/trauma in medically emergent conditions will also be admissible, subject to the ceiling of CGHS rates applicable as per entitlement, when treatment is necessitated in such

hospitals being situated near the place of illness/trauma and when no other empaneled/government facility is available nearby or due to circumstances beyond the control of the beneficiary. Emergency treatment certificate to be issued by the treating doctor must be submitted by the beneficiary along with the claim documents. In case the emergency treatment certificate is not submitted by the beneficiary, the genuineness of the emergency condition / treatment would be evaluated by the Medical Board of NEIGRIHMS.

12. **Medical Reimbursement Claim (MRC)**

(a) **Medical Reimbursement Claim in case of living beneficiary:** Following documents to be submitted by the beneficiaries for MRC:

(i) Application for MRC as given in Annexure 'C'. A separate form should be used for each beneficiary.

(ii) All invoice bills.

(iii) Prescriptions.

(iv) Cash memos.

(v) Non-Availability Certificate (if applicable).

(vi) Essentiality certificate (Certificate A–in the case of patients who are not admitted to hospital for treatment. Certificate B-in the case of patients who are admitted to hospital for treatment as per Annexure 'D').

(vii) Copy of referral (required only if medical attendance/treatment is availed in hospital other than NEIGRIHMS, Shillong).

(viii) A copy of discharge summary attached in case of IPD treatment.

(ix) Checklist for MRC (Annexure 'E').

(x) Emergency treatment certificate (in case required).

(xi) Other relevant documents as required.

All the supporting documents should be signed (with official stamp) by the Authorized Medical Attendant of the case.

(b) **Medical Reimbursement Claim in case original papers have been lost:** in case of lost original documents, the beneficiary is required to submit the following documents:

- Photocopies of claim papers.
- Affidavit on stamp paper (Annexure 'F').

(c) **Medical Reimbursement Claim in case of death of beneficiary: In case of death of the beneficiary, the dependent is** required to submit the following documents:

- Affidavit on Stamp Paper for claiming medical reimbursement (Annexure 'G').
- No objection certificate from legal heirs of the beneficiaries (Annexure 'H').
- Death Certificate.

(d) **Time-limit for submission of Medical Reimbursement claim (MRC):** The beneficiary must submit claims for reimbursement of medical expenses within six months of the completion of treatment for the particular spell of illness. The competent authority may consider condoning delays in submitting medical bills on a case-by-case basis, based on the merits of each case.

13. In the event of any ambiguity in the interpretation of the provisions mentioned in this document, the provisions of the Central Services (Medical Attendance) Rules 1944 and the Central Government Health Scheme, as amended from time to time, shall apply. The decision of the M/o Health & Family Welfare, will be final.

This is being issued with the approval of competent authority.

Annexure 'A'

APLLICATION FOR EMPLOYEE HEALTH SCHEME

Please tick (✓) which is applicable and strike out of (×) whichever not applicable

1. Name of the applicant .....

2. Category: Please tick (✓) whichever is appropriate

a) Service Employee: Regular ☐ / Adhoc ☐ / Temporary status ☐

/ on deputation ☐

b) Resident: Senior Resident ☐

3. Designation: ..... Name of the Department:

.....

4. Basic pay: .....Blood Group:

.....

5. Office Address:

.....

.....

6. Permanent Address: .....

.....

7. Mobile Number: ..... Emergency Contact No: .....

8. E-mail address: ..... Date of Birth: .....

9. Date of Joining: ☐☐ ☐☐ ☐☐☐☐

D / D M / M Y / Y /Y/ Y

10. Date of superannuation (in case of serving NEIGRIHMS employee)

☐☐ ☐☐ ☐☐☐☐

D / D M / M Y/ Y / Y/ Y

11. Date of superannuation (in case of serving NEIGRIHMS employee)

D	/	D		M	/	M	Y / Y / Y / Y	

12. Details of dependent (including self)

(*Please see definition of family in the instructions before filling up this Column)

Sl. No	Name of family member & dependent	Relationship with Employee	Date of Birth	Gender	Blood Group	Marital Status	Mobile No.	Email ID	(Validity to be filled by Concerned establishment Section)

13. Are all the persons whose names are given above are dependent upon you?

Yes ☐ No ☐

a. Please attach proof of their relationship with you, like copy of Ration Card / Aadhaar card/Election Card/ Passport/Identity Card issued by college/ School University/Bank passbook etc.

b. Please attach proof of dependency in respect of age of son(s) & daughter(s) with reference to dependency criteria attached herewith as mentioned in the instructions.

14. Paste one Photograph of each member of dependent Family members including self.

Name:	Name:	Name:	Name: .....
Sign:	Sign:	Sign:	Sign:
Name:	Name:	Name:	Name: .....
Sign:	Sign:	Sign:	Sign:

a. I certify that my family members as above are wholly dependent on me.

b. I undertake to intimate immediately if there is any change in dependency criteria of my family members included in this application form. If I fail to intimate and if the authorities come to know of the same, then the E.H.S. facility is liable to be withdrawn by NEIGRIHMS and appropriate authority will be free to initiate any action against me.

c. I undertake to surrender the EHS card(s) on my leaving the NEIGRIHMS, Shillong on completion of tenure/ retirement/termination/ resignation or on ceasing to be eligible of EHS benefits.

d. I certify that the information furnished by me in this application has been verified to be correct and that no information has been concealed or has been misrepresented and I stand by the same.

(Signature of applicant)

Date:

Place:

(Forwarded by Head of Dept / Section)

(Signature of Head of Dept / Section)

Date:

Place:

DECLARATION

1. I hereby declare that my father /mother/ father-in-law/ mother-in-law namely .....is /are wholly dependent upon me and that he/she/they normally reside with me at Shillong.

2. I also certify that my father namely ..... and mother namely .....are dependent on me and their income from all sources including Pension/Family pension and Pension equivalent of DCRG does not exceed Rs.9000+DR per month plus the amount of Dearness Relief there on.
3. I certify that my son ..... Age.....years is unmarried/unemployed and wholly dependent on me.
4. I certify that my daughter ..... Age.....years is unmarried/unemployed and wholly dependent on me.
5. I undertake to surrender the E.H.S. Card on my leaving the Institute on completion of tenure/ retirement/ termination of service, resignation etc.

(Signature of applicant)

Date:

Place:

(TO BE VERIFIED BY THE CONCERNED ESTABLISHMENT SECTION)

1. The information furnished by the applicant has been verified from his service records and found to be correct. It is recommended that a E.H.S No ..... to be issued to Mr /Ms. / Dr. ..... Designation..... who is working in Department/Section.....
2. Finance division NEIGRIHMS has been intimated about required deduction towards of the E.H.S. subscription every month from the salary of the applicant.
3. It is requested to consider for the issue of New E.H.S. photo Cards to the beneficiary / beneficiaries as per E.H.S. token card.

Signature of the authorized signatory with seal

Date:

Place:

(To be filled in by the E.H.S. Cell)

E.H.S No:_____has been allotted to the applicant by the E.H.S. Cell.

Signature of the authorized signatory with seal

Date:

Place:

INSTRUCTIONS

Definition of Family: The term 'family' shall mean beneficiary's spouse, children (including legally adopted children, children taken as wards & stepchildren), parents, divorced/ abandoned/ or separated from their husband/widowed daughters and unmarried/ divorced / abandoned or separated from their husband / widowed sisters, brothers & stepmother wholly dependent upon the beneficiary and normally residing with the beneficiary or in a station other than the beneficiary's headquarter. Age-limits of dependent son/daughter for the purpose of availing medical facilities is as indicated below (as per CGHS guidelines):

(i)	Son	Till he starts earning or attains the age of 25 years or gets married, whichever is earlier
(ii)	Daughter	Till she starts earning or gets married, irrespective of the age limit, whichever is earlier.
(iii)	Son suffering from any permanent disability of any kind (physical or mental)	Irrespective of age-limit
(iv)	Dependent divorced abandoned or separated from their husband/ widowed daughters and dependent married divorced abandoned or separated their husband widowed sisters.	Irrespective of age-limit
(v)	Minor brother(s)	Up to the age of becoming a major

For the purpose of availing EHS facility for disabled sons above 25 years, please attach a copy of the certificate of disability issued by the competent authority.

The Following Documents are to be enclosed:

1. Proof of Residence/Stay of dependents-(copy of Ration Card/ Adhaar card Election Card/ Passport Identity Card issued by college/ School University/Bank pass book etc...
2. Proof of age of son
3. Attested Copy of Disability certificate issued by Competent Authority (in case of dependent son aged 25 and above)

Annexure 'B'

NON-AVAILABILITY CERTIFICATE

(on the letter head of the authorized pharmacy)

This is to certify that the following medicine (s) prescribed is/are not available at the Institute's Pharmacy as on_____(date):

1.

2.

3.

4.

5.

6.

For_____(Name of the Authorized Official)

Signature of the authorized signatory with seal

Date:

Place:

Annexure 'C'

EMPLOYEE HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the EHS Card holder in BLOCK LETTERS)

1. (a) Name of the EHS card Holder:

   (b) EHS Card Number:

   (c) Employee Code Number:

   (d) Ward Entitlement: Pvt./Semi-Pvt./General

   (e) Full Address:

   (f) Mobile telephone number and e-mail:

2. (a) Patient 'name:

   (b) Patient's EHS Number:

   (c) Relationship with the EHS Card holder:

3. Name & address of the hospital/diagnostic centre/Imaging centre:

4. Whether the hospital/diagnostic/ imaging centre is empanelled under EHS/CGHS: Yes/No

5. Treatment for which reimbursement claimed:

(a) OPD Treatment / Test & investigations

(b) Indoor Treatment

6. Whether treatment was taken in emergency: Yes/No

7. Whether prior permission was taken for the treatment: Yes/No

8. Whether subscribing to any health/medical insurance scheme: Yes/No

if yes amount claimed/received

9. Details of Medical Advance taken, if any:

10. Total amount Claimed:

(a) OPD Treatment:

(b) Indoor treatment:

(c) Test/Investigation:

11. Name of the Bank .....

A/C Number..... Branch MICR Code:.....IFSC Code.....

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 an EHS beneficiary and the EHS card was valid at the time of treatment. My monthly EHS contribution is deducted from my salary. I agree to the reimbursement as is admissible under the rules.

Signature of the EHS Card Holder

Date:

Place:

Annexure 'D'

ESSENTIALITY CERTIFICATE

CERTIFICATE 'A'

(To be completed in the case of patients **WHO ARE NOT ADMITTED** to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss.....wife/son/daughter of Mr./Mrs/Miss..... employed in the .....

I Dr .....hereby certify:

(a) that I charged and received Rs.....for consultation on (dates to be given) at my consulting room at the residence of the patient.

(b) that I charged and received Rs..... for administering..... intravenous / intra-muscular/ subcutaneous injections on.....(Dates to be given) at .....my consulting Room/the residence of the patient.

(c) that the injections administered were not/were for immunizing or prophylactic purposes.

(d) that the patient has been under treatment at ..... hospital / my consulting room 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. The medicines are not stocked in the..... (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Sl. No.	Name of medicine	Price (INR)

(e) that the patient is/was suffering from ..... and is/was under my treatment from.....to.....

(f) that the patient is /was not given pre-natal or post-natal treatment.

(g) that the X-ray laboratory test etc. for which an expenditure of INR..... was incurred on undertaken was necessary and were undertaken on my advice at ..... (name of the hospital or laboratory).

(h) that I referred the patient to Dr ..... and that the necessary approval of the..... (Nam of the Chief Administrative Officer of the State) as required under the rules was obtained;

(i) that the patient did not require/required hospitalization.

Signature of AMA/Designation of the
Medical officer and hospital/ dispensary
to which attached.

Date:

Place:

N.B.: certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by the medical officer in all cases.

ESSENTIALITY CERTIFICATE

CERTIFICATE 'B'

(To be completed in the case of patients **WHO ARE ADMITTED** to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss.....wife/son/daughter of Mr./Mrs/Miss..... .....employed at .....

PART-A

1. Dr .....hereby certify:

(a) That the patient was admitted to hospital on the advice of officer/on my advice of..... .....(name of the medical officer) / on my advice:

(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. The medicines are not stocked in the..... (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

Sl. No.	Name of medicine	Price (INR)

(c) that the injections administered were / were not for Immunizing for prophylactic purposes.

(d) that the patient is/was suffering from ..... and is / was under treatment from.....to .....

(e) that the X-ray, laboratory test etc. for which an expenditure of INR.....was incurred were necessary and were undertaken on my advice (name of hospital or laboratory):

(f) that I called on Dr..... for specialist consultation and that the necessary approval of the.....(Name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.

Signature and Designation of the

Medical Officer-in-charge of the case at the hospital.

Date:

Place:

PART B

Certify that the patient has been under treatment at the..... hospital and that the service of the special nurses for which an expenditure of ₹.....was incurred, vide hills and receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature and Designation of the

Medical Officer-in-charge of the case at the hospital.

Date:

Place:

COUNTERSIGNED

*I certify that the patient has been under treatment at the.....Hospital and the facilities provide were the minimum which were essential for the patient's treatment.

Medical Superintendent

..... Hospital

Date:

Place:

NOTE: CERTIFICATES NOT APPLICABLE SHOULD BE STRUCK OFF. CERTIFICATE (B) IS COMPULSORY AND MUST BE FILLED IN BY THE MEDICAL OFFICER IN ALL CASES.

Annexure 'E'

Document Checklist for Medical Reimbursement through EHS

Sl. No.	Details of the Document submitted	Yes/No	Page No.
1	EHS Number		
2	Self -Explanatory letter form beneficiary Explaining emergency circumstances		
3	Application for MRC		
4	Non-Availability Certificate (if applicable)		
5	Copies of all the prescription		
6	Essentiality certificate		
7	Copy of referral		
8	A copy of discharge summary attached in case of IPD treatment		
9	Original Bills Attested both by consultant & EHS beneficiary		
10	List of all medicines, Laboratory tests investigations.		
11	Permission copy of Medical Board/Director NEIGRIHMS, Shillong (if applicable)/ Intimation copy to EHS during emergency for approval of treatment outside NEIGRIHMS, Shillong.		
12	Photocopies of claim papers and an affidavit on stamp paper in case original papers have been lost.		

13	Affidavit on Stamp Paper for claiming medical reimbursement, No objection certificate from legal heirs of the beneficiaries & Death Certificate for claim in case of death of the beneficiary.		
14	Bank Details (Salary Account Details) number only		

Annexure 'F'

Proforma for Affidavit for Duplicate Claim Paper Bills on Stamp Paper

.....son/wife/daughter of.....and resident of .....have lost/misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim paper from any source and that the original papers are traced. I shall not stake claim against original bills in future and that in the event I receive any cheque againstthe original bills in future, I shall return the same to competent authority.

Signature of the EHS Card Holder

Date:

Place:

Verified by Notary

Annexure 'G'

Proforma for Affidavit on Stamp Paper for Medical Claim Reimbursement

IN CASE DEATH OF AN EHS CARD HOLDER

I.....Husband/Wife/Son/Daughter of late.....and resident of..... .....hereby submit the medical reimbursement claim pertaining to treatment of my husband/wife/father/mother late shri/smt .....who has expired on ..... (Copy of Death Certificate is enclosed)

Late Shri/Smt... .....has left behind the following other legal heirs, none of whom have any objection if the entire reimbursement amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp paper is enclosed.

Signature of Deponent

Date:

Place:

Attested by Notary Public

Annexure 'H'

Proforma for No Objection Certificate on Stamp Paper

(I).We_____S/O,_____D/O_____

late Shri_____

(II) S/o_____D/o_____Late

Shri _____

(III) _____

(IV) _____

Being the legal heir of Late Shri/Smt_____have

no objection if the entire amount reimbursable pertaining to the treatment of late Shri/

Smt_____is paid to

Shri/Smt_____

(i) Signature-	(II) Signature-	(III) Signature-
Name-	Name-	Name-
Address-	Address-	Address-

Verified by Notary Public

पूर्वोत्तर इंदिरा गांधी क्षेत्रीय स्वास्थ एवं आयुर्विज्ञान संस्थान, शिलांग
NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES, SHILLONG
(भारत सरकार, स्वास्थ्य एवं परिवार कल्याण मंत्रालय, स्वायत संस्थान)
(An Autonomous Institute, Ministry of Health and Family Welfare, Government of India)
निदेशक ब्लॉक, मावडीयांगडीयांग, शिलांग - 793018 मेघालय
Director's Block, Mawdiangdiang, Shillong - 793018 Meghalaya
NEIGRIHMS
E-mail- info.neigrihms@nic.in
dda-office@neigrihms.gov.in
www.neigrihms.gov.in
EPABX (0364) 2538025
Tel: (0364) 2538013/2538010

F. No.

F.No. ESTT-I/5/2026-Estt.I Dated: _____

NOTIFICATION

Subject: Implementation of Employee Health Scheme (EHS) at NEIGRIHMS, Shillong – reg.

The undersigned is directed to inform that the Ministry of Health and Family Welfare, Government of India, vide Letter No. U.12012/47/2024-H-III [FTS-8296558] dated 10.06.2026, has conveyed the approval of the Hon'ble Minister for Health & Family Welfare, in his capacity as President of the Governing Council of NEIGRIHMS, for implementation of the **contributory Employee Health Scheme (EHS) at NEIGRIHMS, Shillong**, as per the EHS Policy Document enclosed with the said approval.

The Employee Health Scheme is hereby notified for implementation as per provisions, terms and conditions contained in the approved EHS Policy Document and shall come from date of notification.

Terms and conditions including eligibility for coverage and applicable Rates of Contribution (mentioned below) in the approved EHS Policy Document as attached herewith is uploaded in the Institute's website alongwith this notification for general information of all concerned.

Sl. No.	Pay Level	Monthly Contribution
1	Levels 1–5	₹250/-
2	Level 6	₹450/-
3	Levels 7–11	₹650/-
4	Level 12 and above	₹1,000

The deduction of contributions shall be done by Accounts Section on monthly basis at the time of payment of salaries etc. Payment of Fixed Medical Allowance shall be discontinued to retired pensioners on implementation of the EHS.

This is issued with the approval of the Director, NEIGRIHMS, Shillong.

Digitally signed by
PAWAN DEEP
Date: 07-10-2026
12:50:46

(Lt. Cdr. Pawan Deep)
Deputy Director (Admn)

F. No. ESTT-I/5/2026-Estt.I Dated: _____

Copy for information and request for circulation to all concerned to:

1. The Dean, Academics, NEIGRIHMS, Shillong.
2. Medical Superintendent, NEIGRIHMS, Shillong.
3. All Heads of Departments, NEIGRIHMS, Shillong.
4. The Principal, College of Nursing, NEIGRIHMS, Shillong.
5. All Heads of Sections/Units in Hospital/Admin Block/Library etc
6. The Accounts Officer, NEIGRIHMS for necessary action.
7. The Administrative Officer, Establishment-I Section, NEIGRIHMS for necessary action.
8. The Programmer, IT Cell, NEIGRIHMS for uploading in the Institute's website.
9. The Medical Record Officer, NEIGRIHMS for necessary action.

Sd/-
(Lt. Cdr. Pawan Deep)
Deputy Director (Admn)

INTER - DEPARTMENTAL NOTE (IDN)
ESTABLISHMENT SECTION – II

ID Note No. EST-II-EHS/1/2025-Estt-II
Dated 21st July 2026

Sub: Employee Health Scheme (EHS) Document of NEIGRIHMS Shillong- regarding

I am directed to enclose herewith the Ministry's letter F. No. U.12012/47/2024-H-III [FTS-829655s] dated 10.06.2026 received from U/S Hospital Section-III, MoH&FW, conveying the approval of the Hon'ble HFM, in his capacity as President, Governing Council for implementation of the contributory Employee Health Scheme (EHS) at NEIGRIHMS, Shillong, as per the enclosed EHS document.

This is for favour of information and further necessary action at your end.

This issues with the approval of the Competent Authority, NEIGRIHMS.

Encl. As Above.

Digitally signed by
MORGAN MYLLIEMNGAP
Date: 21-07-2026
10:13:29

Assistant Registrar
Establishment-II Section &
Academics

To,

Administrative Officer,
Establishment-I Section,
NEIGRIHMS, Shillong.

F. No. U.12012/47/2024-H-III [FTS- 8296555]
भारत सरकार / **Government of India**
स्वास्थ्य और परिवार कल्याण मंत्रालय / **Ministry of Health and Family Welfare**
स्वास्थ्य और परिवार कल्याण विभाग / **Department of Health and Family Welfare**
(अस्पताल-III अनुभाग) / **Hospital-III Section**
****

Kartavya Bhavan-1, New Delhi
Dated: 10th June, 2026

To

The Director,
NEIGRIHMS,
Shillong, Meghalaya-793018

Subject: Employee Health Scheme (EHS) Document of NEIGRIHMS Shillong-reg.

Sir,

I am directed to refer to your letter No. NEIGR-E.II/31/2019/Pt.I dated 13.09.2024 on the subject cited above and to convey the approval of Hon'ble HFM, in his capacity as President of the Governing Council (GC), for implementation of the contributory Employee Health Scheme (EHS) at NEIGRIHMS, Shillong, as per the enclosed EHS document.

2. This should be placed before the Governing Council for ratification in its next meeting.

3. This issues with the approval of the competent authority, MoHFW.

Yours faithfully,

Encl.: A/a.

Digitally signed by
ANURAG TIWARI
Date: 10-06-2026
18:10:02

(Anurag Tiwari)
Under Secretary to the Govt. of India
☏ : 011- 2401 3282

EMPLOYEE HEALTH SCHEME (EHS) FOR NEIGRIHMS, SHILLONG

POLICY DOCUMENT

1. Background

The 5th SFC recommended that serving employees should be entitled to medical treatment and reimbursement which was approved by the 4th Governing Council. However, retired employees have not been extended the same benefits & they currently receive a fixed medical allowance of INR 1000 (Rupees One Thousand only) per month. 40th SFC proposed that the retired employees should be given the same medical treatment and reimbursement benefits as serving employees. However, it was decided by the MoHFW, GoI, after examination of the proposal that it was not feasible, as NEIGRIHMS serving employees are not entitled to the CGHS facility. Further, in pursuance of the suggestions of the 3rd EC, the Institute prepared a draft EHS document for medical treatment and reimbursement for retired employees on the lines of the Employee Health Scheme of AIIMS, New Delhi.

2. Purpose: The purpose of this document is to prescribe procedures and guidelines for the Employee Health Scheme (EHS) of NEIGRIHMS, Shillong.

3. Eligibility criteria for the beneficiaries.

a. The scheme shall apply to all:

i. Regular employees of NEIGRIHMS, Shillong, and their dependent family members.

ii. Retired employees of NEIGRIHMS, Shillong and their dependent family members.

iii. Employees of Central/State Government, Central/State Autonomous bodies, on deputation to NEIGRIHMS, Shillong and their dependent family members till the duration of their deputation.

Anuj Tiwari

iv. Resident doctors (SRDs & JRDs) employed under the 'Residency scheme' of the Government of India, and their dependents during the period of their tenure.

v. Special cases under old and new pension wherever disability and/or family pension is eligible.

vi. Ad-hoc faculty and resident doctors

vii. Employee (s) who join on deputation or tenure appointment in the Institute and are willing to opt for subscription to EHS post completion of their tenure, with an affidavit that they have not subscribed to any other health insurance scheme of any other central / state government office/autonomous bodies.

b. ***The scheme shall <u>NOT</u> apply to***:

i. Contractual and outsourced workforce.

ii. Persons working on research projects and related schemes.

4. Family and Dependents

a. The term 'family' shall mean beneficiary's spouse, children (including legally adopted children, children taken as wards & stepchildren), parents, divorced/ abandoned/ or separated from their husband/widowed daughters and unmarried/ divorced/abandoned or separated from their husband/widowed sisters, brothers & stepmother, wholly dependent upon the beneficiary and normally residing with the beneficiary or in a station other than the beneficiary's headquarter.

b. The income limit for dependency of the family members (other than spouse) is Rs. 9,000/- plus the amount of Dearness Relief admissible on Rs. 9,000/- on the date of consideration of the claim (vide MoHFW, GoI, Office Memorandum No. S-11012/2/2016-CGHS-P dated 08-11-2016). This ceiling of Rs. 9,000/-

p.m. is subject to revision as may be notified by the Government of India from time to time and that such revision shall be effective from the date of notification by the Government of India.

c. Both male & female employee has a choice to include either her dependent parents or her dependent parents-in law. The option exercised can be changed only once during service.

d. Age-limit of dependent sons/daughters for the purpose of availing medical facilities is as indicated below:

Relationship of the family member with the employee	Family member will be considered as dependent on the employee
Son	till he starts earning/attains the age of 25 years/gets married, whichever is earlier. Note: An **'unmarried'** son of an employee suffering from permanent disability of any kind (physical or mental) will be entitled to EHS facility even after attaining the age of 25 years. (Ref: MoHFW OM No. 4-24/96-C&P/CGHS(P)/EHS dated 07.05.2018)
Daughter	she starts earning/gets married, irrespective of her age, whichever is earlier.
Son with permanent disability of any kind	irrespective of his age limit.

Dependent divorced/ abandoned/ or separated from their husband/widowed daughters and dependent unmarried/ divorced/abandoned or separated from their husband/widowed sisters	irrespective of their age limit.
Minor brother(s)	up to the age of becoming a major.

Note: When both husband and wife are employed, the declaration for family and dependents shall be as per Central Services (Medical Attendance) Rules, 1944.

5. Contribution to the scheme:

Beneficiaries shall make a monthly contribution to the scheme which will be deducted from their salary. The monthly deduction will be based on the pay levels, as per 7th CPC, the details of which are mentioned below (Ref: MoHFW, GoI, Office Memorandum No. S-11011/11/2016-CGHS-P/EHS dated 09-01-2017):

Sl. No	Levels in the pay matrix	Monthly contribution (INR)
1.	Levels 1-5	250.00
2.	Level 6	450.00
3.	Levels 7-11	650.00
4.	Level 12 and above	1000.00

Employees / Pensioners* may avail of the EHS facility as per qualifying criteria given below:

(a) Eligible ex-employee (who had retired by taking VRS or on Superannuation before the introduction of the EHS facility): lump sum amount (equivalent to 10 years contribution, as per the level in the 7th CPC pay matrix mentioned in the table above).

(b) Upon retirement (in accordance with the Pension Rules) employees who had previously subscribed to EHS, will have to pay a lump sum amount (10 years contribution) as per the level in the 7th CPC pay matrix mentioned in the table above.

(c) Contribution to be made by the pensioner/family pensioners would be the amount that they were subscribing at the time of their retirement or at the time of death of the beneficiary.

(d) Payment of additional amount as a result of any revision in the rates of contribution, as and when notified, will apply to all beneficiaries (except to those who make 10 years lump sum contribution) as in Sl. No. 1 and 2 of table regarding contribution to the scheme.

6. **Admission to the Scheme:**

Eligible beneficiaries will be required to fill out an Application (Annexure 'A') for enrolling in the scheme and submit the same with requisite supporting documents for verification.

7. **Issue of EHS/Health Card:**

After verification, eligible beneficiaries will be issued an EHS Identity card (beneficiary and eligible dependents). The card will have to mandatorily be provided/used by the beneficiary to avail of facilities available at NEIGRIHMS, Shillong, as per their entitlement including OPD consultation, IPD treatment, laboratory, and radiological investigations etc. free of charge.

MEDICAL ENTITLEMENT OF EHS BENEFICIARY

8. **Treatment at NEIGRIHMS, Shillong:**

(a) **OPD Treatment**

(i) **OPD services** for necessary consultation/examination in the OPD of NEIGRIHMS, Shillong.

(ii) **Investigations and Treatment Procedures:** Diagnostic tests and treatment procedures as advised by the consultants and which are available at NEIGRIHMS, Shillong, will be free of charge for beneficiaries. For any test that is not available at NEIGRIHMS (certified by the MS), the beneficiary will be referred to another centre and the amount will be reimbursed as per rules and CGHS rates or actuals, whichever is lower.

(iii) **Purchase of prescribed medicine:** Beneficiary may procure all prescribed medicines from the market till such time that the NEIGRIHMS pharmacy is made operational. Once the NEIGRIHMS pharmacy is operational, the beneficiary will be bound to take the prescribed medicines from the NEIGRIHMS pharmacy. In case the medicine/s prescribed by the consultant/specialist, is/are not available in the NEIGRIHMS pharmacy, the same will be procured andprovided to the beneficiary by the NEIGRIHMS Pharmacy. In case of emergency, the beneficiary may be advised to procure the same from the market and seek reimbursement as per rules. A "Non-Availability Certificate" (Annexure 'B') issued by the NEIGRIHMS Pharmacy / NEIGRIHMS stores willhave to be provided by the beneficiary for processing the reimbursement.

(b) IPD Treatment

(i) **Ward Entitlement:** Type of ward / room allotted in the hospital will depend upon the basic pay drawn by the employee as per 7th CPC. The entitlement of the ward will be as under:

Sl. No.	Corresponding Basic Pay drawn by Officer in 7th CPC per month	Entitlement
1	Upto Rs. 36,500/-	General Ward
2	Upto Rs. 36,500 to Rs. 50,500/-	Semi-Private
3	Above Rs. 50,500/-	Private Ward

(iv) **Procurement of Drugs/Consumables/Surgical Items:** Beneficiary may procure all prescribed medicines / consumables / surgical items from the market till such time that the NEIGRIHMS pharmacy is made operational. Once the NEIGRIHMS pharmacy is operational, the same will be arranged from the NEIGRIHMS pharmacy to the beneficiary. If any of the required items are not available in the NEIGRIHMS Pharmacy, the same will be procured and provided to the beneficiary by the NEIGRIHMS Pharmacy. In case of emergency, the beneficiary may be advised to procure the same from the market and seek reimbursement as per rules. A "Non-Availability Certificate" (Annexure 'B') issued by the NEIGRIHMS Pharmacy will have to be provided by the beneficiary for processing the reimbursement.

9. **Treatment at places other than NEIGRIHMS, Shillong:** If a beneficiary avails of medical facilities in places other than NEIGRIHMS, Shillong, the Central Services (Medical Attendance) Rules, 1944 as amended from time to time, shall apply.

(a) **Referral by NEIGRIHMS, Shillong to other hospitals:** If the Consultant/Specialist at NEIGRIHMS, Shillong is of the opinion that a beneficiary should receive medical treatment at another hospital, either due to the non-availability of a particular treatment/procedure/facility in the institute or due to the serious or special nature of the illness, consultant may, with the approval of the Medical Board (mandatory requirement unless the delay would endanger the patient's health), refer the patient to the nearest government/CGHS empanelled private hospital where the particular treatment / procedure / facility is available for consultation or further care. In certain cases, the Medical Board may approve referral to government/CGHS empanelled private hospital other than nearest government/CGHS empanelled private hospital on case-to-case basis, subject to the approval by the Competent

Authority. The expenses incurred will be reimbursed as per CGHS rates or actuals, whichever is lower.

(b) **Travelling allowance:** If a beneficiary is referred to the government/CGHS empanelled private hospital, as per Sl. No. 9(a), they will be entitled to travel allowance for the journey to and from the referred hospital, as per the Central Service (Medical Attendance) Rules, 1944. To claim this allowance, the beneficiary must produce a certificate in writing from the consultant.

(c) **Purchase of prescribed medicine:** If a beneficiary attends a nearest government/CGHS empanelled private hospital as an OPD patient after being referred by the consultant/specialist at NEIGRIHMS, Shillong and gets the prescription for medicines, the same may be procured from any pharmacy, however, the reimbursements will be as per CGHS rates or actuals, whichever is lower.

(d) **Investigations:** Tests and investigations advised at the referred hospital should preferably be done there. However, if it is not feasible or the facility is not available at the referred hospital, the tests and investigations can be availed at any other hospitals, laboratories, or imaging centres but it shall be reimbursed as per CGHS rates or actual, whichever is lower.

(e) **Treatment Procedures:** In the case of elective planned medical treatment procedures, beneficiaries can avail medical treatment from referred nearest government/CGHS empanelled hospital. They will be reimbursed as per CGHS rates or actuals, whichever is lower. The referral should be only for services or facilities not available at NEIGRIHMS, Shillong. Under special circumstances, and with prior permission from the competent authority, reimbursement may be made for unlisted investigations, treatment, and procedures, referral treatments, etc. Ex-post facto sanction can be granted only in exceptional and

extremely deserving cases. The following documents are required to be submitted for permission:

- Request letter to give permission, from employee clearly mentioning the name of the unlisted investigations/treatment/procedure and the name of the empanelled hospital where he intends to avail the facility.
- Authorized Medical attendant/Government specialist advise clearly mentioning said investigations/treatment/procedure. Vague advice like advised surgery without mentioning the actual procedure is not acceptable.
- One estimate from empanelled hospital where patient intends to take treatment.
- Other relevant medical documents in support of beneficiary illness.

10. **Special situations when NEIGRIHMS referral is not required:** A serving beneficiary who is out of station on official duty/leave or a retired beneficiary who does not reside in Shillong, Meghalaya can avail medical facilities, including specialist consultation, tests and investigations, indoor medical care, and treatment procedures in any nearest government (like AIIMS, PGIMER etc.) or CGHS empaneled private hospital in that city without a referral from consultant / specialist at NEIGRIHMS, Shillong. Reimbursement in such cases will be made as per CGHS rates or actuals, whichever is lower.

11. **Treatment in Emergency:** In emergency situations, beneficiaries can go directly to any government or CGHS empaneled hospital near their residence or place of illness without a formal referral from NEIGRIHMS. Treatment in private hospitals that are not empaneled under the CGHS near the place of illness/trauma in medically emergent conditions will also be admissible, subject to the ceiling of CGHS rates applicable as per entitlement, when treatment is necessitated in such

hospitals being situated near the place of illness/trauma and when no other empaneled/government facility is available nearby or due to circumstances beyond the control of the beneficiary. Emergency treatment certificate to be issued by the treating doctor must be submitted by the beneficiary along with the claim documents. In case the emergency treatment certificate is not submitted by the beneficiary, the genuineness of the emergency condition / treatment would be evaluated by the Medical Board of NEIGRIHMS.

12. **Medical Reimbursement Claim (MRC)**

(a) **Medical Reimbursement Claim in case of living beneficiary:** Following documents to be submitted by the beneficiaries for MRC:

(i) Application for MRC as given in Annexure 'C'. A separate form should be used for each beneficiary.

(ii) All invoice bills.

(iii) Prescriptions.

(iv) Cash memos.

(v) Non-Availability Certificate (if applicable).

(vi) Essentiality certificate (Certificate A–in the case of patients who are not admitted to hospital for treatment. Certificate B-in the case of patients who are admitted to hospital for treatment as per Annexure 'D').

(vii) Copy of referral (required only if medical attendance/treatment is availed in hospital other than NEIGRIHMS, Shillong).

(viii) A copy of discharge summary attached in case of IPD treatment.

(ix) Checklist for MRC (Annexure 'E').

(x) Emergency treatment certificate (in case required).

(xi) Other relevant documents as required.

All the supporting documents should be signed (with official stamp) by the Authorized Medical Attendant of the case.

(b) **Medical Reimbursement Claim in case original papers have been lost:** In case of lost original documents, the beneficiary is required to submit the following documents:

- Photocopies of claim papers.
- Affidavit on stamp paper (Annexure 'F').

(c) **Medical Reimbursement Claim in case of death of beneficiary: In case of death of the beneficiary, the dependent is** required to submit the following documents:

- Affidavit on Stamp Paper for claiming medical reimbursement (Annexure 'G').
- No objection certificate from legal heirs of the beneficiaries (Annexure 'H').
- Death Certificate.

(d) **Time-limit for submission of Medical Reimbursement claim (MRC):** The beneficiary must submit claims for reimbursement of medical expenses within six months of the completion of treatment for the particular spell of illness. The competent authority may consider condoning delays in submitting medical bills on a case-by-case basis, based on the merits of each case.

13. In the event of any ambiguity in the interpretation of the provisions mentioned in this document, the provisions of the Central Services (Medical Attendance) Rules 1944 and the Central Government Health Scheme, as amended from time to time, shall apply. The decision of the M/o Health & Family Welfare, will be final.

This is being issued with the approval of competent authority.

Annexure 'A'

APLLICATION FOR EMPLOYEE HEALTH SCHEME

Please tick (✓) which is applicable and strike out of (×) whichever not applicable

1. Name of the applicant .....

2. Category: Please tick (✓) whichever is appropriate

a) Service Employee: Regular ☐ / Adhoc ☐ / Temporary status ☐

/ on deputation ☐

b) Resident: Senior Resident ☐

3. Designation: ..... Name of the Department:

.....

4. Basic pay: .....Blood Group:

.....

5. Office Address:

.....

.....

6. Permanent Address: .....

.....

7. Mobile Number: ..... Emergency Contact No: .....

8. E-mail address: ..... Date of Birth: .....

9. Date of Joining: ☐☐ ☐☐ ☐☐☐☐ D / D M / M Y / Y /Y/ Y

10. Date of superannuation (in case of serving NEIGRIHMS employee)

☐☐ ☐☐ ☐☐☐☐ D / D M / M Y/ Y / Y/ Y

11. Date of superannuation (in case of serving NEIGRIHMS employee)

D	/ D	M	/ M	Y	/ Y	/ Y	/ Y

12. Details of dependent (including self)

(*Please see definition of family in the instructions before filling up this Column)

Sl. No	Name of family member & dependent	Relationship with Employee	Date of Birth	Gender	Blood Group	Marital Status	Mobile No.	Email ID	(Validity to be filled by Concerned establishment Section)

13. Are all the persons whose names are given above are dependent upon you?

Yes ☐ No ☐

a. Please attach proof of their relationship with you, like copy of Ration Card / Aadhaar card/Election Card/ Passport/Identity Card issued by college/ School University/Bank passbook etc.

b. Please attach proof of dependency in respect of age of son(s) & daughter(s) with reference to dependency criteria attached herewith as mentioned in the instructions.

14. Paste one Photograph of each member of dependent Family members including self.

Name:	Name:	Name:	Name: .....
Sign:	Sign:	Sign:	Sign:
Name:	Name:	Name:	Name: .....
Sign:	Sign:	Sign:	Sign:

a. I certify that my family members as above are wholly dependent on me.

b. I undertake to intimate immediately if there is any change in dependency criteria of my family members included in this application form. If I fail to intimate and if the authorities come to know of the same, then the E.H.S. facility is liable to be withdrawn by NEIGRIHMS and appropriate authority will be free to initiate any action against me.

c. I undertake to surrender the EHS card(s) on my leaving the NEIGRIHMS, Shillong on completion of tenure/ retirement/termination/ resignation or on ceasing to be eligible of EHS benefits.

d. I certify that the information furnished by me in this application has been verified to be correct and that no information has been concealed or has been misrepresented and I stand by the same.

(Signature of applicant)

Date:

Place:

(Forwarded by Head of Dept / Section)

(Signature of Head of Dept / Section)

Date:

Place:

DECLARATION

1. I hereby declare that my father /mother/ father-in-law/ mother-in-law namely .....is /are wholly dependent upon me and that he/she/they normally reside with me at Shillong.

2. I also certify that my father namely ..... and mother namely .....are dependent on me and their income from all sources including Pension/Family pension and Pension equivalent of DCRG does not exceed Rs.9000+DR per month plus the amount of Dearness Relief there on.
3. I certify that my son ..... Age.....years is unmarried/unemployed and wholly dependent on me.
4. I certify that my daughter ..... Age.....years is unmarried/unemployed and wholly dependent on me.
5. I undertake to surrender the E.H.S. Card on my leaving the Institute on completion of tenure/ retirement/ termination of service, resignation etc.

(Signature of applicant)

Date:

Place:

(TO BE VERIFIED BY THE CONCERNED ESTABLISHMENT SECTION)

1. The information furnished by the applicant has been verified from his service records and found to be correct. It is recommended that a E.H.S No ..... to be issued to Mr /Ms. / Dr. ..... Designation..... who is working in Department/Section.....
2. Finance division NEIGRIHMS has been intimated about required deduction towards of the E.H.S. subscription every month from the salary of the applicant.
3. It is requested to consider for the issue of New E.H.S. photo Cards to the beneficiary / beneficiaries as per E.H.S. token card.

Signature of the authorized signatory with seal

Date:

Place:

(To be filled in by the E.H.S. Cell)

E.H.S No:_____has been allotted to the applicant by the E.H.S. Cell.

Signature of the authorized signatory with seal

Date:

Place:

INSTRUCTIONS

Definition of Family: The term 'family' shall mean beneficiary's spouse, children (including legally adopted children, children taken as wards & stepchildren), parents, divorced/ abandoned/ or separated from their husband/widowed daughters and unmarried/ divorced / abandoned or separated from their husband / widowed sisters, brothers & stepmother wholly dependent upon the beneficiary and normally residing with the beneficiary or in a station other than the beneficiary's headquarter. Age-limits of dependent son/daughter for the purpose of availing medical facilities is as indicated below (as per CGHS guidelines):

(i)	Son	Till he starts earning or attains the age of 25 years or gets married, whichever is earlier
(ii)	Daughter	Till she starts earning or gets married, irrespective of the age limit, whichever is earlier.
(iii)	Son suffering from any permanent disability of any kind (physical or mental)	Irrespective of age-limit
(iv)	Dependent divorced abandoned or separated from their husband/ widowed daughters and dependent married divorced abandoned or separated their husband widowed sisters.	Irrespective of age-limit
(v)	Minor brother(s)	Up to the age of becoming a major

For the purpose of availing EHS facility for disabled sons above 25 years, please attach a copy of the certificate of disability issued by the competent authority.

The Following Documents are to be enclosed:

1. Proof of Residence/Stay of dependents-(copy of Ration Card/ Adhaar card Election Card/ Passport Identity Card issued by college/ School University/Bank pass book etc...
2. Proof of age of son
3. Attested Copy of Disability certificate issued by Competent Authority (in case of dependent son aged 25 and above)

Annexure 'B'

NON-AVAILABILITY CERTIFICATE

(on the letter head of the authorized pharmacy)

This is to certify that the following medicine (s) prescribed is/are not available at the Institute's Pharmacy as on_____(date):

1.

2.

3.

4.

5.

6.

For_____(Name of the Authorized Official)

Signature of the authorized signatory with seal

Date:

Place:

Annexure 'C'

EMPLOYEE HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the EHS Card holder in BLOCK LETTERS)

1. (a) Name of the EHS card Holder:

   (b) EHS Card Number:

   (c) Employee Code Number:

   (d) Ward Entitlement: Pvt./Semi-Pvt./General

   (e) Full Address:

   (f) Mobile telephone number and e-mail:

2. (a) Patient 'name:

   (b) Patient's EHS Number:

   (c) Relationship with the EHS Card holder:

3. Name & address of the hospital/diagnostic centre/Imaging centre:

4. Whether the hospital/diagnostic/ imaging centre is empanelled under EHS/CGHS: Yes/No

5. Treatment for which reimbursement claimed:

(a) OPD Treatment / Test & investigations

(b) Indoor Treatment

6. Whether treatment was taken in emergency: Yes/No

7. Whether prior permission was taken for the treatment: Yes/No

8. Whether subscribing to any health/medical insurance scheme: Yes/No

if yes amount claimed/received

9. Details of Medical Advance taken, if any:

10. Total amount Claimed:

(a) OPD Treatment:

(b) Indoor treatment:

(c) Test/Investigation:

11. Name of the Bank .....

A/C Number..... Branch MICR Code:.....IFSC Code.....

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 an EHS beneficiary and the EHS card was valid at the time of treatment. My monthly EHS contribution is deducted from my salary. I agree to the reimbursement as is admissible under the rules.

Signature of the EHS Card Holder

Date:

Place:

Annexure 'D'

ESSENTIALITY CERTIFICATE

CERTIFICATE 'A'

(To be completed in the case of patients **WHO ARE NOT ADMITTED** to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss.....wife/son/daughter of Mr./Mrs/Miss..... employed in the .....

I Dr .....hereby certify:

(a) that I charged and received Rs.....for consultation on (dates to be given) at my consulting room at the residence of the patient.

(b) that I charged and received Rs..... for administering..... intravenous / intra-muscular/ subcutaneous injections on.....(Dates to be given) at .....my consulting Room/the residence of the patient.

(c) that the injections administered were not/were for immunizing or prophylactic purposes.

(d) that the patient has been under treatment at ..... hospital / my consulting room 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. The medicines are not stocked in the..... (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Sl. No.	Name of medicine	Price (INR)

(e) that the patient is/was suffering from ..... and is/was under my treatment from.....to.....

(f) that the patient is /was not given pre-natal or post-natal treatment.

(g) that the X-ray laboratory test etc. for which an expenditure of INR..... was incurred on undertaken was necessary and were undertaken on my advice at ..... (name of the hospital or laboratory).

(h) that I referred the patient to Dr ..... and that the necessary approval of the..... (Nam of the Chief Administrative Officer of the State) as required under the rules was obtained;

(i) that the patient did not require/required hospitalization.

Signature of AMA/Designation of the
Medical officer and hospital/ dispensary
to which attached.

Date:

Place:

N.B.: certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by the medical officer in all cases.

ESSENTIALITY CERTIFICATE

CERTIFICATE 'B'

(To be completed in the case of patients **WHO ARE ADMITTED** to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss.....wife/son/daughter of Mr./Mrs/Miss.....employed at .....

PART-A

1. Dr .....hereby certify:

(a) That the patient was admitted to hospital on the advice of officer/on my advice of..... .....(name of the medical officer) / on my advice:

(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. The medicines are not stocked in the..... (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

Sl. No.	Name of medicine	Price (INR)

(c) that the injections administered were / were not for Immunizing for prophylactic purposes.

(d) that the patient is/was suffering from ..... and is / was under treatment from.....to .....

(e) that the X-ray, laboratory test etc. for which an expenditure of INR.....was incurred were necessary and were undertaken on my advice (name of hospital or laboratory):

(f) that I called on Dr..... for specialist consultation and that the necessary approval of the.....(Name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.

Signature and Designation of the

Medical Officer-in-charge of the case at the hospital.

Date:

Place:

PART B

Certify that the patient has been under treatment at the..... hospital and that the service of the special nurses for which an expenditure of ₹.....was incurred, vide hills and receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature and Designation of the

Medical Officer-in-charge of the case at the hospital.

Date:

Place:

COUNTERSIGNED

*I certify that the patient has been under treatment at the.....Hospital and the facilities provide were the minimum which were essential for the patient's treatment.

Medical Superintendent

..... Hospital

Date:

Place:

NOTE: CERTIFICATES NOT APPLICABLE SHOULD BE STRUCK OFF. CERTIFICATE (B) IS COMPULSORY AND MUST BE FILLED IN BY THE MEDICAL OFFICER IN ALL CASES.

Annexure 'E'

Document Checklist for Medical Reimbursement through EHS

Sl. No.	Details of the Document submitted	Yes/No	Page No.
1	EHS Number		
2	Self -Explanatory letter form beneficiary Explaining emergency circumstances		
3	Application for MRC		
4	Non-Availability Certificate (if applicable)		
5	Copies of all the prescription		
6	Essentiality certificate		
7	Copy of referral		
8	A copy of discharge summary attached in case of IPD treatment		
9	Original Bills Attested both by consultant & EHS beneficiary		
10	List of all medicines, Laboratory tests investigations.		
11	Permission copy of Medical Board/Director NEIGRIHMS, Shillong (if applicable)/ Intimation copy to EHS during emergency for approval of treatment outside NEIGRIHMS, Shillong.		
12	Photocopies of claim papers and an affidavit on stamp paper in case original papers have been lost.		

13	Affidavit on Stamp Paper for claiming medical reimbursement, No objection certificate from legal heirs of the beneficiaries & Death Certificate for claim in case of death of the beneficiary.		
14	Bank Details (Salary Account Details) number only		

Annexure 'F'

Proforma for Affidavit for Duplicate Claim Paper Bills on Stamp Paper

.....son/wife/daughter of.....and resident of .....have lost/misplaced the original paper or the same are not traceable. I hereby give an undertaking that I have not received any payment against the original bills/claim paper from any source and that the original papers are traced. I shall not stake claim against original bills in future and that in the event I receive any cheque againstthe original bills in future, I shall return the same to competent authority.

Signature of the EHS Card Holder

Date:

Place:

Verified by Notary

Annexure 'G'

Proforma for Affidavit on Stamp Paper for Medical Claim Reimbursement

IN CASE DEATH OF AN EHS CARD HOLDER

I.....Husband/Wife/Son/Daughter of late.....and resident of..... .....hereby submit the medical reimbursement claim pertaining to treatment of my husband/wife/father/mother late shri/smt .....who has expired on ..... (Copy of Death Certificate is enclosed)

Late Shri/Smt... .....has left behind the following other legal heirs, none of whom have any objection if the entire reimbursement amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp paper is enclosed.

Signature of Deponent

Date:

Place:

Attested by Notary Public

Annexure 'H'

Proforma for No Objection Certificate on Stamp Paper

(I).We_____S/O,_____D/O_____

late Shri_____

(II) S/o_____D/o_____Late

Shri _____

(III) _____

(IV) _____

Being the legal heir of Late Shri/Smt_____have

no objection if the entire amount reimbursable pertaining to the treatment of late Shri/

Smt_____is paid to

Shri/Smt_____

(i) Signature-	(II) Signature-	(III) Signature-
Name-	Name-	Name-
Address-	Address-	Address-

Verified by Notary Public