

**Government of West Bengal  
Finance Department  
Medical Cell, Writers 'Building**

No. 48 -F (MED)WB

Dated:29.03.2022

**ORDER**

**Sub: Introduction of online processing of Advance claim through WBHS Portal under West Bengal Health Scheme.**

Online processing of medical reimbursement claim through WBHS Portal has been introduced vide Finance Department Notification No. 127-F(MED)WB dated 26.11.2021. But, processing of advance drawal against cost of ongoing OPD/IPD treatment is still being processed manually on the basis of the estimate from the recognised hospitals under the WBHS.

As such, online processing of such advance claim through WBHS Portal and making payments thereof through WBIFMS Portal in integrated mode was under active consideration for some time past.

Now, after careful consideration, the Governor is pleased to introduce the online processing of medical advance claim through WBHS Portal with the following guidelines, new set of Forms and Pro-forma Estimate from the Hospital for processing and settlement of the claim:-

1. Guidelines of process flow for online advance claim through WBHS Portal mentioned in Appendix-I.
2. Form-C5 of advance claim for Out-Patient Department (OPD) treatment in State Aided /Private Empanelled/ Outside State Enlisted Hospital.
3. Form-C6 of advance claim for In-Patient Department (IPD) treatment in State Aided /Private Empanelled/ Outside State Enlisted Hospital.
4. Pro-forma of Cost Estimate (Annexure-III) for Out Patient Department (OPD) treatment.
5. Pro-forma of Cost Estimate (Annexure-IV) for In Patient Department (IPD) treatment.

Online processing of advance claim through WBHS Portal is optional for all treatments till 30.06.2022 and it is mandatory thereafter.

This has the approval of Principal Secretary, Finance Department, Government of West Bengal.

Enclosures: As stated



**ALOK KUMAR MUKHERJEE, WBA & AS  
Joint Secretary, Finance Department  
Government of West Bengal**

**Appendix-I**

(As per Order No.48-F(MED)WB dated.29.03.2022)

**(Process flow for online advance claim through WBHS Portal)**

1. Only enrolled employee (pensioner is not eligible) under WBHS may draw advance for meeting up the expenditure for ongoing/future treatment in recognized hospitals within State or enlisted hospitals outside State.
2. An employee will have to collect duly signed and stamped Estimate of Expenditure from treating the hospital for taking advance.
3. Treating hospital will issue Cost Estimate for a maximum period of 60(sixty) days for OPD and 15(fifteen) days for IPD treatment in a specified format to the employee.
4. Empanelled private hospital of the State shall issue **system generated Cost Estimate** from WBHS Portal using their credential. On the other hand State aided hospitals and enlisted hospital outside State will issue in **manual mode**.
5. On request empanelled hospital authority will issue system generated Cost Estimate using their credential in WBHS Portal. When hospital generates it in portal, a 12 (twelve) digit unique ID will be generated and enfacd in the top right of Cost Estimate. Hospital authority will hand over duly signed and stamped Cost Estimate to the employee or his/her relatives. In case of any wrong information mentioned in Cost Estimate, hospital can reject previous one for issuing a fresh one.
6. When employee collect portal generated Cost Estimate from private empanelled hospital of State, the information of advance claim will be filled automatically and to be shown as a claim in "**Claim Pending for Submission**" under '**My Claim**' menu in the login of employee in WBHS Portal. On the other hand, when employee gets Cost Estimate from State aided hospitals or enlisted hospital outside State, s/he has to incorporate the information of advance in WBHS Portal using his/her personal login in the Advance menu under '**My Claim**'. Employee will submit the claim electronically.
7. Claim will reach automatically to the Operator (Reimbursement) with whom the employee is mapped for reimbursement claim processing.
8. After online submission, employee shall have to take a print out of system generated form of claim submitted. Then s/he signs in the appropriate space provided in the form. S/he will have to attach all necessary enclosures chronologically mentioned in last part of the claim form. Finally signed copy of such claim form must be submitted physically to the office of the Head of Office at the earliest.
9. After receiving the advance claim at office of the Head of Office, the sanction order will be generated as per guidelines as laid down under Clause No. 13 to 23 of Appendix-I of Finance Department Notification No. 127-F(MED)WB dated 26.11.2021.
10. Appendix-II of Notification No. 127-F(MED)WB dated 26.11.2021 shall be applicable for PAO/Treasury Bill preparation in TR Form-68C and subsequent disbursement.



**SRI ALOKE KUMAR MUKHERJEE, WBA & AS**  
**Joint Secretary, Finance Department**  
**Government of West Bengal**



**Form -C5****Out-Patient Department (OPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme**

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office where Employee attached)

To

The ..... (Designation of HoO)

..... (Name of the Office)

..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards Advance of cost of Out-Patient Department (OPD) treatment at state aided/ private empanelled / enlisted hospital under West Bengal Health Scheme as per details stated below:

**Part-I[General Information]**

| 1. Details of Employee/Pensioner.         |                                                                  |                                                                                                          |  |
|-------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|
| Full Name<br>(in Block letters)           |                                                                  | HRMS ID                                                                                                  |  |
| Enrolment ID No.                          |                                                                  | Claim Application ID.<br>(To be filled at the time of<br>online entry from the end<br>of Head of Office) |  |
| 2. Details of Patient, Treating Hospital. |                                                                  |                                                                                                          |  |
| 2.1                                       | Name of the Patient                                              |                                                                                                          |  |
| 2.2                                       | Name of hospital where treatment is going on<br>or to be availed |                                                                                                          |  |

**Part-II [Details of Cost Component of Estimate]**

| 3. Estimate of Hospital                                                                                                          |                                                                                           |                                           |                                      |                                                                          |                               |
|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|-------------------------------|
| 3.1 No. of days for which hospital produced<br>Estimated Expenditure                                                             |                                                                                           |                                           |                                      |                                                                          | <input type="text"/> ( ) Days |
| 3.2 Details of OPD Diseases for which advance is sought                                                                          |                                                                                           |                                           |                                      |                                                                          |                               |
| Sl. No.                                                                                                                          | Particulars                                                                               | Name of diseases                          |                                      |                                                                          |                               |
| 3.2.1                                                                                                                            | Name of OPD Diseases<br>for which advance is<br>required(tick mark in<br>appropriate box) | <input type="checkbox"/> Bitathallasaemia | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Carcinoma<br>including<br>Multiple<br>Myelomais |                               |
| 4. Cost Component of OPD treatments as per estimate submitted by state aided/ private empanelled/outside state enlisted hospital |                                                                                           |                                           |                                      |                                                                          |                               |
| Sl. No.                                                                                                                          | Name of Component                                                                         | Nos.                                      | Period                               |                                                                          | Amount (Rs.)                  |
|                                                                                                                                  |                                                                                           |                                           | From                                 | To                                                                       |                               |
| 4.1                                                                                                                              | Consultation fees                                                                         |                                           |                                      |                                                                          |                               |
| 4.2                                                                                                                              | Cost of pathological and radiological<br>Investigations                                   |                                           |                                      |                                                                          |                               |
| 4.3                                                                                                                              | Cost of medicines                                                                         |                                           |                                      |                                                                          |                               |

## Manual Advance Application Form

|       |                                  |  |  |  |  |
|-------|----------------------------------|--|--|--|--|
| 4.4   | Cost of implant / special device |  |  |  |  |
| 4.5   | Miscellaneous (specify)          |  |  |  |  |
| Total |                                  |  |  |  |  |

### Part-III [Advance Amount Selection Clause]

| Sl. No. | Particulars                                                        | Amount (Rs.) |
|---------|--------------------------------------------------------------------|--------------|
| 1       | Maximum admissible amount for Advance (80 % of total of sl. no. 4) |              |
| 2       | Amount of Advance Applied for                                      |              |

### Amount of Advance Claim:[ Lowest amount of Sl. No. 1 and 2 of Part-III]

|           |        |
|-----------|--------|
| Rs:       |        |
| In words: | Rupees |

### Part-IV [Details of Advance Claimant]

| Sl. No. | Name of Claimant | Relation |
|---------|------------------|----------|
| 1       |                  |          |

### Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

#### [List of Enclosures]

| Sl. No. | Name/Particulars of enclosures to be attached                                                                       | Enclosed or not              |                             |
|---------|---------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1       | Enrolment certificate of the patient                                                                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2       | Original Cost Estimate issued by treating hospital                                                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3       | Prognosis Report of patient issued by the Treating Consultant                                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4       | Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5       | Any other instruments (Specify)                                                                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :





**Form -C5****Out-Patient Department (OPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme**

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(Generated by Employee from WBHS Portal)

To

The ..... (Designation of HoO)

..... (Name of the Office)

..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards advance for cost of Out-Patient Department (OPD) treatment at state aided/ private empanelled / enlisted hospital under West Bengal Health Scheme as per details stated below:

**Part-I[General Information]**

| 1. Details of Employee/Pensioner         |                                                               |                       |  |
|------------------------------------------|---------------------------------------------------------------|-----------------------|--|
| Full Name                                |                                                               | HRMS ID.              |  |
| Enrolment ID No.                         |                                                               | Claim Application ID. |  |
| Bed Entitlement                          |                                                               | Date of Enrolment     |  |
| 2. Details of Patient, Treating Hospital |                                                               |                       |  |
| 2.1                                      | Name of the Patient                                           |                       |  |
|                                          | Beneficiary ID                                                |                       |  |
|                                          | Relationship with Employee                                    |                       |  |
| 2.2                                      | Name of hospital where treatment is going on or to be availed |                       |  |
|                                          | Code of Hospital                                              |                       |  |
|                                          | Class of Entitlement of Hospital                              |                       |  |
|                                          | Address of Hospital                                           |                       |  |

**Part-II [Details of Cost Component of Estimate]**

| 3. Estimate of Hospital                                                                                                             |                                                                                  |                          |                  |                               |              |                          |                                        |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------|------------------|-------------------------------|--------------|--------------------------|----------------------------------------|
| 3.1 No. of days for which hospital produced Estimated Expenditure                                                                   |                                                                                  |                          |                  | ( <input type="text"/> ) Days |              |                          |                                        |
| 3.2 Details of OPD Diseases for which advance is sought                                                                             |                                                                                  |                          |                  |                               |              |                          |                                        |
| Sl. No.                                                                                                                             | Particulars                                                                      |                          | Name of diseases |                               |              |                          |                                        |
| 3.2.1                                                                                                                               | Name of OPD Diseases for which advance is required(Tick mark in appropriate box) | <input type="checkbox"/> | Bitathallasaemia | <input type="checkbox"/>      | Hepatitis C  | <input type="checkbox"/> | Carcinoma including Multiple Myelomais |
| 4. Cost Component of OPD treatment as per Estimate submitted by the state aided/ private empanelled/outside state enlisted hospital |                                                                                  |                          |                  |                               |              |                          |                                        |
| Sl. No.                                                                                                                             | Name of Component                                                                | Nos.                     | Period           |                               | Amount (Rs.) |                          |                                        |
|                                                                                                                                     |                                                                                  |                          | From             | To                            |              |                          |                                        |
| 4.1                                                                                                                                 | Consultation fees                                                                |                          |                  |                               |              |                          |                                        |
| 4.2                                                                                                                                 | Cost of pathological and radiological                                            |                          |                  |                               |              |                          |                                        |

## Online Advance Application Form

|       |                                  |  |  |  |  |
|-------|----------------------------------|--|--|--|--|
|       | Investigations                   |  |  |  |  |
| 4.3   | Cost of medicines                |  |  |  |  |
| 4.4   | Cost of implant / special device |  |  |  |  |
| 4.5   | Miscellaneous (specify)          |  |  |  |  |
| Total |                                  |  |  |  |  |

### Part-III [Advance Amount Selection Clause]

| Sl. No. | Particulars                                                        | Amount (Rs.) |
|---------|--------------------------------------------------------------------|--------------|
| 1       | Maximum admissible amount for Advance (80 % of total of sl. no. 4) |              |
| 2       | Amount of Advance Applied for                                      |              |

### Amount of Advance Claim:[ Lowest amount of Sl. No. 1 and 2 of Part-III]

|           |        |
|-----------|--------|
| Rs:       |        |
| In words: | Rupees |

### Part-IV [Details of Advance Claimant]

| Sl. No. | Name of Claimant | Relation |
|---------|------------------|----------|
| 1       |                  |          |

### Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim is found false and mala fide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

### [List of Enclosures]

| Sl. No. | Name/Particulars of enclosures to be attached                 | Enclosed or not              |                             |
|---------|---------------------------------------------------------------|------------------------------|-----------------------------|
| 1       | Original Cost Estimate issued by treating hospital            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2       | Prognosis Report of patient issued by the Treating Consultant | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3       | Any other instruments (Specify)                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :





**Form –C6****In-Patient Department (IPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme***(As per Order No. 48-F(MED)WB, dated 29/03/2022)**(Applicable for those who are not able to claim through online by himself/herself and online entry shall have to be done by the office of Head of Office where Employee attached)*

To  
 The ..... (Designation of HoO)  
 ..... (Name of the Office)  
 ..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs. .... (Rupees.....) towards  
**Advance** of cost of In-Patient Department (IPD) treatment at state aided/ private empanelled / outside state enlisted hospital under West Bengal Health Scheme as per details stated below:

**Part-I[General Information]**

| 1. Details of Employee                   |                                                                  |                                                                                                          |  |
|------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|
| Full Name<br>(in Block letters)          |                                                                  | HRMS ID                                                                                                  |  |
| Enrolment ID No.                         |                                                                  | Claim Application ID.<br>(To be filled at the time of<br>online entry from the end of<br>Head of Office) |  |
| 2. Details of Patient, Treating Hospital |                                                                  |                                                                                                          |  |
| 2.1                                      | Name of the Patient                                              |                                                                                                          |  |
| 2.2                                      | Name of hospital where treatment is<br>going on or to be availed |                                                                                                          |  |

**Part-II [Details of Cost Component of Estimate]**

| 3. Estimate of Hospital                                           |                              |                    |                         |                               |
|-------------------------------------------------------------------|------------------------------|--------------------|-------------------------|-------------------------------|
| 3.1 No. of days for which hospital produced Estimated Expenditure |                              |                    |                         | <input type="text"/> ( ) days |
| 3.2 Estimate cost of Package Treatment                            |                              |                    |                         |                               |
| Sl. No.                                                           | Name of Procedures/ Packages | Procedure Code     | Amount (Rs.)            |                               |
| 3.2.1                                                             |                              |                    |                         |                               |
| 3.2.2                                                             |                              |                    |                         |                               |
| 3.2.3                                                             |                              |                    |                         |                               |
| 3.2.4                                                             |                              |                    |                         |                               |
| 3.2.5                                                             |                              |                    |                         |                               |
|                                                                   |                              |                    | Total                   |                               |
| 3.3 Estimate cost of Implants Used                                |                              |                    |                         |                               |
| Sl. No.                                                           | Name of Implants             | Coded or Non-coded | Implants Code, if coded | Amount (Rs.)                  |
| 3.3.1                                                             |                              |                    |                         |                               |
| 3.3.2                                                             |                              |                    |                         |                               |
| 3.3.3                                                             |                              |                    |                         |                               |
| 3.3.4                                                             |                              |                    |                         |                               |
| 3.3.5                                                             |                              |                    |                         |                               |

|                                                            |                                                       |                                                            |                             |
|------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|-----------------------------|
|                                                            |                                                       | Total (Rs.)                                                |                             |
| <b>3.4 Estimate cost of Non-Package Treatment.</b>         |                                                       |                                                            |                             |
| Sl. No.                                                    | Name of Component                                     | Amount (Rs.)                                               |                             |
| 3.4.1                                                      | Room/ Bed rent                                        |                                                            |                             |
| 3.4.2                                                      | Consultation fees.                                    |                                                            |                             |
| 3.4.3                                                      | Cost of pathological and radiological investigations. |                                                            |                             |
| 3.4.4                                                      | Cost of medicines.                                    |                                                            |                             |
| 3.4.5                                                      | Cost of consumables                                   |                                                            |                             |
| 3.4.6                                                      | Charges of special nursing/aya                        |                                                            |                             |
| 3.4.7                                                      | Miscellaneous. (specify)                              |                                                            |                             |
|                                                            |                                                       | <b>Amount of Total Estimate submitted by Hospital(Rs.)</b> |                             |
|                                                            |                                                       | (amount mentioned in 3.2+ 3.3+3.4)                         |                             |
| <b>3.5 Mode of Treatment</b>                               |                                                       |                                                            |                             |
| Availing Cashless Facility? (Tick mark in appropriate box) |                                                       | Yes <input type="checkbox"/>                               | No <input type="checkbox"/> |

**Part-III [Advance Amount Selection Clause]**

| Sl. No. | Particulars                                                                                                                                                        | Amount (Rs.) |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| 1       | Maximum admissible amount for Advance<br>If answer of 3.5 is yes {80 % of(3.2+ 3.3+3.4) minus Rs. 1,00,000.00} or If<br>answer of 3.5 is No 80 % of (3.2+ 3.3+3.4) |              |
| 2       | Amount of Advance Applied for                                                                                                                                      |              |

**Amount of Advance Claim:[Lowest amount of Sl. No. 1 and 2 of Part-III]**

|           |        |
|-----------|--------|
| Rs.       |        |
| In words: | Rupees |

**Part-IV [Details of Advance Claimant]**

| Sl. No. | Name of Claimant | Relation |
|---------|------------------|----------|
| 1       |                  |          |

**Part-V [Declaration of Employee]**

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

**[List of Enclosures]**

| Sl. No. | Name/Particulars of enclosures to be attached      | Enclosed or not              |                             |
|---------|----------------------------------------------------|------------------------------|-----------------------------|
| 1       | Enrolment certificate of the patient               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2       | Original Cost Estimate issued by treating hospital | Yes <input type="checkbox"/> | No <input type="checkbox"/> |





## Manual Advance Claim Form

|   |                                                                                                                     |                              |                             |
|---|---------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 3 | Prognosis Report of patient issued by the Treating Consultant                                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4 | Filled ECS mandate form in case of those, whose bank details is not available in IFMS (In case of first claim only) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5 | Any other instruments (Specify)                                                                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :



**Form –C6****In-Patient Department (IPD) Treatment in State Aided/ Private Empanelled/Outside State Enlisted hospital under West Bengal Health Scheme**

(As per Order No. 48-F(MED)WB, dated 29/03/2022)

(Generated by Employee from WBHS Portal)

To  
 The ..... (Designation of HoO)  
 ..... (Name of the Office)  
 ..... (Office Address of HoO)

Sir/Madam,

I am submitting a prayer of Rs..... (Rupees.....) towards Advance of cost of In-Patient Department (IPD) treatment at state aided/ private empanelled / outside state enlisted hospital under West Bengal Health Scheme as per details stated below:

**Part-I[General Information]**

|                                                 |                                                               |                       |  |
|-------------------------------------------------|---------------------------------------------------------------|-----------------------|--|
| <b>1. Details of Employee</b>                   |                                                               |                       |  |
| Full Name                                       |                                                               | HRMS ID.              |  |
| Enrolment ID No.                                |                                                               | Claim Application ID. |  |
| Bed Entitlement                                 |                                                               | Date of Enrolment     |  |
| <b>2. Details of Patient, Treating Hospital</b> |                                                               |                       |  |
| 2.1                                             | Name of the Patient                                           |                       |  |
|                                                 | Beneficiary ID                                                |                       |  |
|                                                 | Relationship with Employee                                    |                       |  |
| 2.2                                             | Name of hospital where treatment is going on or to be availed |                       |  |
|                                                 | Code of Hospital                                              |                       |  |
|                                                 | Class of Entitlement of Hospital                              |                       |  |
|                                                 | Address of Hospital                                           |                       |  |

**Part-II [Details of Cost Component of Estimate]**

|                                                                          |                              |                    |                               |              |
|--------------------------------------------------------------------------|------------------------------|--------------------|-------------------------------|--------------|
| <b>3. Estimate of Hospital</b>                                           |                              |                    |                               |              |
| <b>3.1 No. of days for which hospital produced Estimated Expenditure</b> |                              |                    | ( <input type="text"/> ) days |              |
| <b>3.2 Estimate cost of Package Treatment</b>                            |                              |                    |                               |              |
| Sl. No.                                                                  | Name of Procedures/ Packages | Procedure Code     | Amount (Rs.)                  |              |
| 3.2.1                                                                    |                              |                    |                               |              |
| 3.2.2                                                                    |                              |                    |                               |              |
| 3.2.3                                                                    |                              |                    |                               |              |
| 3.2.4                                                                    |                              |                    |                               |              |
| 3.2.5                                                                    |                              |                    |                               |              |
|                                                                          |                              |                    | Total                         |              |
| <b>3.3 Estimate cost of Implants Used</b>                                |                              |                    |                               |              |
| Sl. No.                                                                  | Name of Implants             | Coded or Non-coded | Implants Code, if coded       | Amount (Rs.) |
| 3.3.1                                                                    |                              |                    |                               |              |
| 3.3.2                                                                    |                              |                    |                               |              |





## Online Advance Claim Form

|                                                                                                |                                                       |                              |                             |  |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------|-----------------------------|--|
| 3.3.3                                                                                          |                                                       |                              |                             |  |
| 3.3.4                                                                                          |                                                       |                              |                             |  |
| 3.3.5                                                                                          |                                                       |                              |                             |  |
| Total (Rs.)                                                                                    |                                                       |                              |                             |  |
| <b>3.4 Estimate cost of Non-Package Treatment.</b>                                             |                                                       |                              |                             |  |
| Sl. No.                                                                                        | Name of Component                                     | Amount (Rs.)                 |                             |  |
| 3.4.1                                                                                          | Room/ Bed rent                                        |                              |                             |  |
| 3.4.2                                                                                          | Consultation fees.                                    |                              |                             |  |
| 3.4.3                                                                                          | Cost of pathological and radiological investigations. |                              |                             |  |
| 3.4.4                                                                                          | Cost of medicines.                                    |                              |                             |  |
| 3.4.5                                                                                          | Cost of consumables                                   |                              |                             |  |
| 3.4.6                                                                                          | Charges of special nursing/aya                        |                              |                             |  |
| 3.4.7                                                                                          | Miscellaneous. (specify)                              |                              |                             |  |
| <b>Amount of Total Estimate submitted by Hospital(Rs.)</b><br>(amount mentioned in 3.2+ 3.3+4) |                                                       |                              |                             |  |
| <b>3.5 Mode of Treatment</b>                                                                   |                                                       |                              |                             |  |
| Availing Cashless Facility? (Tick mark in appropriate box)                                     |                                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |  |

### Part-III [Advance Amount Selection Clause]

| Sl. No. | Particulars                                                                                                                                                         | Amount (Rs.) |
|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| 1       | Maximum admissible amount for Advance<br>If answer of 3.5 is yes {80 % of (3.2+ 3.3+3.4) minus Rs. 1,00,000.00} or If<br>answer of 3.5 is No 80 % of (3.2+ 3.3+3.4) |              |
| 2       | Amount of Advance Applied for                                                                                                                                       |              |

**Amount of Advance Claim: [ Lowest amount of Sl. No. 1 and 2 of Part-III]**

|           |        |
|-----------|--------|
| Rs.       |        |
| In words: | Rupees |

### Part-IV [Details of Advance Claimant]

| Sl. No. | Name of Claimant | Relation |
|---------|------------------|----------|
| 1       |                  |          |

### Part-V [Declaration of Employee]

I hereby declare that the statements made in the application of claim for advance is true to the best of my knowledge and belief. The person, for whom medical expenses to be incurred, is a beneficiary of West Bengal Health Scheme and possessed a valid enrolment certificate at the time treatment. I will be held responsible and liable to face any disciplinary action taken against me in terms of WBS (CCA) Rules 1971 if the claim is found false and malafide due to any suppression of facts. I am enclosing the following instrument(s) to substantiate my claim in sequential manner.

**[List of Enclosures]**



## Online Advance Claim Form

| Sl. No. | Name/Particulars of enclosures to be attached                 | Enclosed or not              |                             |
|---------|---------------------------------------------------------------|------------------------------|-----------------------------|
| 1       | Original Cost Estimate issued by treating hospital            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2       | Prognosis Report of patient issued by the Treating Consultant | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3       | Any other instruments (Specify)                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Date:

Signature of the Employee/Claimant :

Name in Block Letters :

Designation :





## **Annexure-III**

(As per Order No.48-F(MED)WB, dated 29/03/2022)

### **Cost Estimate**

(Required for applying advance of OPD treatment)

| <b>A. Patient Information</b> |                                                                                         |         |
|-------------------------------|-----------------------------------------------------------------------------------------|---------|
| Sl. No.                       | Particulars                                                                             | Details |
| 1                             | Name of the patient                                                                     |         |
| 2                             | Beneficiary ID of the patient                                                           |         |
| 3                             | Enrolment ID of the employee                                                            |         |
| 4                             | Duration of treatment (maximum admissible duration 60 days)                             | From To |
| 5                             | Name of disease [Bita-Thallsaemia/ Hepatitis-C/ Carcinoma including Multiple Myelomais] |         |
| 6                             | Expected nos. of consultation                                                           |         |

| <b>B. Estimate</b> |                                                      |              |
|--------------------|------------------------------------------------------|--------------|
| Sl. No.            | Name of cost component                               | Amounts (Rs) |
| 1                  | Consultation fees                                    |              |
| 2                  | Cost of pathological and radiological Investigations |              |
| 3                  | Cost of medicines                                    |              |
| 4                  | Cost of implant / special device                     |              |
| 5                  | Miscellaneous (if any)                               |              |
| Total              |                                                      |              |
| Rupees in words:   |                                                      |              |

Other declarations if any (given by hospital)

Signature of Treating Consultant  
with date and official stamp

Signature of MS/CEO/FD/Admn Officer  
with date and official stamp

**Note:** Cost Estimate shall be issued in official letter head of the hospital.



## **Annexure-IV**

(As per Order No.48-F(MED)WB, dated 29.03.2022)

### **Cost Estimate**

(Required for applying advance of IPD treatment)

| <b>A. Patient Information</b> |                                                                                             |         |
|-------------------------------|---------------------------------------------------------------------------------------------|---------|
| Sl. No.                       | Particulars                                                                                 | Details |
| 1                             | Name of the patient                                                                         |         |
| 2                             | Beneficiary ID of the patient                                                               |         |
| 3                             | Enrolment ID of the employee                                                                |         |
| 4                             | Date or expected date of admission                                                          |         |
| 5                             | Period of package treatment                                                                 | From To |
| 6                             | Period of non-package treatment                                                             | From To |
| 7                             | No. of days for which hospital furnished the estimate (maximum admissible duration 15 days) |         |
| 8                             | Type of IPD treatment [Package (Surgical)/Non-Package / Both Package and Non-package]       |         |
| 9                             | Covering cashless facility                                                                  | Yes/No  |

| <b>B. Estimate for Package(Surgical) Treatment</b> |                                                                                                   |              |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------|
| Sl. No.                                            | Name of cost component                                                                            | Amounts (Rs) |
| 1                                                  | Name of Procedure (if more than one procedure is planned, it has to be mentioned chronologically) |              |
| 2                                                  | Cost of implant used /to be used                                                                  |              |
| Total                                              |                                                                                                   |              |

| <b>C. Estimate for Non-Package Treatment</b> |                                                      |              |
|----------------------------------------------|------------------------------------------------------|--------------|
| Sl. No.                                      | Name of cost component                               | Amounts (Rs) |
| 1                                            | Bed/Room rent                                        |              |
| 2                                            | Consultation fees                                    |              |
| 3                                            | Cost of pathological and radiological Investigations |              |
| 4                                            | Cost of medicines                                    |              |
| 5                                            | Cost of consumables                                  |              |
| 6                                            | Charges of special nursing/ayah                      |              |
| 7                                            | Miscellaneous. (if any)                              |              |
| Total                                        |                                                      |              |

Total Cost (B+C) in figure:

Total Cost in words :

Other declarations if any (given by hospital)

Signature of Treating Consultant  
with date and official stamp

Signature of MS/CEO/FD/Admn Officer  
with date and official stamp

**Note:** Cost Estimate shall be issued in official letter head of the hospital.