Guidelines For Retirees To Claim Medical Reimbursement For OPD Treatment:

1. Medical claim forms for reimbursement of medicines purchased only after 30.03.2020 due to COVID-19 phase is attached at Annexure-1.
2. Retiree has to submit separate claim forms for lab investigations and medicines reimbursement. Completed forms along with relevant documents to be submitted in person in DROP-BOX placed at BEL-GAD Reception or by post to DGM(WELFARE),BEL GAD.
3. Retiree can claim reimbursement for medicines purchased till further orders received from CO.
4. Retiree has to attach prescription of any one type of the following along with claim form:
   -Original /
   -Self Certified (with blue ink pen signed) photocopy of the prescription issued by the treating doctor/hospital on or after 01.10.2019.
5. Prescription issued by treating doctor/hospital on/after 01.10.2019 is valid for purchase of medicines upto one year at a time in case of chronic medicines only.
6. Retirees are requested to send only **ORIGINAL BILLS** for medicine purchased at their end, duplicate bills are not entertained for reimbursement. Kindly check the bill while receiving from the Medical Store (especially from Apollo pharmacy) that bill handed over to retiree is ORIGINAL COPY only.
7. All documents should be self attested and original bill only are eligible for reimbursement.
8. Lab investigations claims to be submitted along with photo copy of self attested test reports.
9. Retirees who are submitting their medical claims for the very first time, has to enclose Cancelled Cheque along with claim form (**for first time only**).
10. Claims without relevant documents will be rejected without notice and any clarification later will not be entertained.

(ONLY FOR MEDICINES) **ANNEXURE-1**

BHARAT ELECTRONICS LIMITED
BHARAT NAGAR GHAZIABAD (UP) Sl.No.....

MEDICAL CLAIM FORM FOR RETIRED EMPLOYEES

(ONLY FOR MEDICINES)

1. Name of Retiree:..... 2. Ex-staff no : .....

3. BERECHS No:..... 4. Mobile no: .....

5. Name of Patient : ..... SELF/ SPOUSE

6. Address : .....

7: Name of the treating Doctor:.....8.Nature of the illness: .....

Medicines details :

S.N	Name of the medicines purchased	Quantity	Bill / Invoice no	Bill date	Amount claimed	Remarks

Certificate/Declaration :

1. Certified that the above medicines expenses were actually incurred by me towards self/spouse.
2. Certified that I have not submitted any other claims in respect of the above expenditure.
3. Certified that I am aware that any of the above particulars / certificate if found incorrect/false in any respect at any time, I shall be liable for debarring me from the BERECHS Scheme, besides penal action and recovery of the amount wrongfully drawn by me.

Date : Signature of Retiree

For OFFICE ONLY

HR Officer Medical Officer Checked (Finance) Account Officer

Passed amount

BHARAT ELECTRONICS LIMITED
BHARAT NAGAR GHAZIABAD (UP) **Sl.No.....**

MEDICAL CLAIM FORM FOR RETIRED EMPLOYEES

(FOR PATHOLOGICAL TESTS/INVESTIGATIONS ONLY)

1.Name of Ex-employee : _____ 2.Ex-Staff No. _____
3.BERCHES No. : _____ 4.Contact Phone No._____
5.Name of Patient : _____ 6.Age of Patient :_____
7.Relationship : _____ 8.Address :_____

Pathological Tests

Sl. No.	Date	Name of Test/ Investigation	Name of hospital or Laboratory	Amount paid by the member	Amount ** Reimbursed (75% of MAT Rates)	Encl

Certificate:
Certified that the above expenses were actually incurred by me and I have not submitted any other claim in respect of the above expenditure.

Date : _____

Signature of Retired Member Employee

For office use only

HR Officer Medical Officer Checked (Finance) Account Officer

Passed Amount_____