APPLICATION FORM FOR PERMISSION FOR GETTING **TREATMENTS / INVESTIGATIONS** DONE FROM CGHS RECOGNIZED PRIVATE HOSPITALS / DIAGNOSTIC CENTRES

S. No	PARTICULARS	
1	Name of CGHS Beneficiary & Card No.	
2	Designation of CGHS Beneficiary	
3	Basic Pay/Pension + Dearness Pay/Relief of CGHS Beneficiary	
4	Name of Section	
5	Detail of tlie Patient and Relationship with the CGHS Beneficiary	

Name of patient	Relationship	CGHS Card No.

6	Name of Hospital / CGHS Dispensary which has prescribed Treatmentl Investigation	Date of Prescription	Name(s) of Treatment / Investigations required.

7	Name and address of CGHS recognized Hospital / Diagnostic Centre from where treatment/investigations are to be done	

I undertake that family member(s) as indicated above is/are dependent upon me and his/her/their income from all sources does not exceed to Rs.3500/- (as per instructions vide OM No. S.11015/10/2011-CGHS (P) dated 13.7.2011). If there is any discrepancy, I shall be fully responsible for the same.
(*strike off if not applicable)

Note : Spouse does not come under this category i.e. income of Rs.3500/-

Dated:_____

_____
Signature of Applicant

Name of Applicant :_____
Designation _____
Section's Name _____
Telephone No. _____

P.S. : Kindly attach the photocopy of CGHS Card and prescription slip.

केन्द्रीय सरकार स्वास्थ्य योजना (सीजीएचएस) द्वारा मान्यता प्राप्त प्राइवेट अस्पताल/निदान केन्द्रों (डाइग्नोस्टिक सेंटर) से उपचार/जांच कराने के लिए अनुमति हेतु आवेदन प्रपत्र

क. स.	विवरण
1	सीजीएचएस लाभार्थी का नाम एवं कार्ड संख्या
2	सीजीएचएस लाभार्थी का पद एवं अनुभाग :-
3	मूल वेतन/पेंशन+महंगाई भत्ता/सीजीएचएस रिलीफ
4	मरीज का विवरण और सीजीएचएस लाभार्थी के साथ संबंध

मरीज का नाम	संबंध	सीजीएचएस कार्ड संख्या

5	अस्पताल/सीजीएचएस अधिकृतता का नाम जिन्होंने उपचार/जांच लिखी है	पर्ची पर निर्देश करने व लिखने की तिथि	अपेक्षित उपचार/जांच का नाम
6	सीजीएचएस मान्यता प्राप्त अस्पताल/निदान केन्द्र का नाम जहां उपचार/जांच की जानी है।		

* मैं वचन देता हूं कि उपरोक्त दर्शाए गए मेरे परिवार के सदस्य पूरी तरह से मेरे ऊपर निर्भर हैं और सभी स्रोतों से इनकी आय रू० 3500/- से ज्यादा नहीं है (ओएम संख्या एस 11015/10/2011-सीजीएचएस (पी) दिनांक 13.7.2011)। यदि इसमें कोई तब्दीली होगी तो उसके लिए मैं पूरी तरह से जिम्मेदार हूं।

(* यदि लागू न हो तो उसे काट दें)

टिप्पणी: पति/पत्नी (स्पाउस) इस श्रेणी में नहीं आते अर्थात रू० 3500/- आय।

दिनांक .....

आवेदक के हस्ताक्षर

आवेदक का नाम

पदनाम एवं अनुभाग :-

टेलीफोन नं .....

कृपया ध्यान दें: कृपया सीजीएचएस कार्ड और डाक्टर की पर्ची की फोटोप्रति संलग्न करें।

APPLICATION FOR CGHS CARD

☐ Applying for New CGHS Card -In case of new pensioner's Card- CGHS Card No. while in service ☐☐☐☐☐☐☐

☐ Applying for New Card to replace existing CGHS Card No. ☐☐☐☐☐☐☐

1. Name of the Applicant: .....

2. Category ☐ Departmental ☐ Services ☐ Pensioners ☐ Others (Pl.Specify)
.....

(Please Tick Departmental if you are posted in the Ministry of Health & Family Welfare/ DGHS / CGHS)
(Please Tick Services if you belong to any specific organized service)

3. Name of Department / Service

4. Designation ..... ☐ Gazetted ☐ Non-Gazetted

5. Scale of Pay ..... Present Pay .....

6. Last Pay / Basic Pension (in case of Pensioners):.....

7. Official Address :.....

.....

8. Residential Address;.....

.....

9. Telephone Number: (O) (R) (M)

10. e-mail ID

11. Date of Superannuation: __/__/____
Date Month Year

12. Are you on Deputation (Central Deputation) Yes / No

13. If yes, likely completion of Deputation

14. Are your services transferable to other cities: Yes / No

15. Details of Family
(* Please see definition of Family before filling up this column)

S.No.	Name of Family member	Relation ship to CGHS Card Holder*	Date of Birth#	Blood Group (optional)
		Self		

{# Please attach Proof of age of Persons mentioned above}

(P.T.O.)

16. Are all the persons whose names are given above are dependant upon you and are residing with you? Yes / No

(Please attach proof of their staying wth you , like copy of Ration Card / Election ID / Pass Port / Identity Card issued by College / School / University / Bank Pass Book , etc.,)

17. Paste one ID Card size of Photograph of each member of Family (including self) whose names are proposed to be included as part of your family in the space given below.

S.No	S.No.	S.No.....	S.No,.....	S.No.....
S.No	S.No.	S.No.....	S.No.....	S.No.....

I Undertake to intimate to CGHS 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 CGHS comes to know of the change then the CGHS facility is liable to be withdrawn by the CGHS and the CGHS and / or appropriate authority will be free to initiate any action against me.

I Undertake to surrender the CGHS Card(s) on my leaving the Ministry / Office on transfer; retirement; termination. Resignation; or on ceasing to be eligible for CGHS benefits.

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.

Encl. Proof of Residence / Stay of dependents
Proof of age of son/ Disability certificate
Surrender Certificate of CGHS Card while in service
Attested copies of PPO & Lasr Pay Certificate

Signature of Applicant.

(TO BE FILLED BY THE SPONSORING AUTHORITY)

The Information furnished by the applicant has been verified and found to be correct. It is recommend that a CGHS Card be issued to Shri /Smt. /Kumari ....., Designation ..... In this Ministry / Department / Organization. Instructions are issued to the concerned Division to start deducting CGHS Subscriptions every month from the salary of the applicant / CGHS Subscriptions are deducted every month from the salary of the applicant. I am authorized sponsoring authority for the issue of CGHS Card and approval of the Competent authority has been obtained.

No.
Date

Signature & Name of
the Sponsoring Authority

Designation (Stamp) with Tel. Number

Verified – by Authorized Signatory, CGHS(HQ)
Signature with Stamp (for CGHS pensioners making card First Time)

To

Chief Medical Officer i/c , CGHS Dispensary No.