

**BHARAT SANCHAR NIGAM LIMITED  
CORPORATE OFFICE**

No. BSNL/ADMN/1

Dated: 22.4.2003

**Office Order**

**Sub: BSNL Employees Medical Reimbursement Scheme – Instructions for operation of the scheme.**

Pursuant to the 'BSNL Employees Medical Reimbursement Scheme' (BSMRS) issued vide this office letter of even no. dated 28.2.2003, the following instructions are issued for operation of the scheme:

1. The abbreviated form of the scheme will be known as 'BSNLMRS' in place of 'BSMRS'.
2. All serving and retired employees of BSNL will be required to exercise their option for either CGHS or BSNLMRS by filling up the prescribed proforma appended at 'Annexure A'. Option, once exercised, can not be changed. It may be noted in this connection that CGHS facility which is, in general, not available for PSU employees, has been extended to BSNL employees who have come en masse on deputation from DOT as a special case. The continuance of this facility is entirely under discretion of the Ministry of Health, and can not be guaranteed by BSNL Management. However, in case the CGHS facility is subsequently withdrawn by the Ministry of Health, the optees of CGHS will automatically have to switch over to BSNLMRS.
3. All serving and retired employees, who opt for BSNLMRS as per para 2 above, are required to fill up a 'Registration Form' for 'BSNLMRS' as appended at 'Annexure B'. While registering for this scheme, the option regarding outdoor treatment, viz. entitlement with voucher/without voucher/treatment from P&T dispensary has to be exercised. Suitable Registration No. and Card will be issued to all the beneficiaries under BSNLMRS.
4. All serving and retired employees registered under BSNLMRS must present their claim for reimbursement of Medical Expenses in the prescribed format which is appended herewith at 'Annexure C' (for outdoor/domiciliary treatment) and 'Annexure D' (for Indoor treatment involving hospitalization). It may be noted that claim for outdoor treatment can be availed only under one of the three options mentioned at paras 2.1.0, 2.1.1 & 2.1.2 of the 'BSNLMRS'. These options are also indicated in the Registration Form. Blank forms will be made available by concerned sections of BSNL. The option regarding mode of outdoor treatment once exercised cannot be changed during the financial year.

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5. The Claim Form shall be supported by the copies of prescriptions alongwith original vouchers ( in duplicate) towards the expenses incurred.
6. The Claim Form along with supporting documents shall be submitted to the sections dealing with Medical Claim. The competent authority for passing the claims in the field units may be fixed up by the CGM concerned. In the Corporate Office, Sr.DDG(Pers) will be the competent authority.
7. A register (preferably computerized) showing the employee-wise detail of claim will be maintained by the section handling such claims. In case of transfer of an employee, the amount claimed towards medical-reimbursement and the balance of entitlement as on date of transfer will be communicated to the new office through LPC.
8. The claim papers duly checked and passed shall be sent to Accounts Branch for payment.
9. Claim for outdoor treatment may be preferred once in a month..
10. List of recognized hospitals shall be notified immediately by all the Heads of Territorial Circles, as outlined in the BSNLMRS, taking into consideration the infrastructure available, quality of service, standard rate of various treatments vis-à-vis the CGHS approved rates etc. The guidelines for this purpose have already been issued vide this office letter of even No. dated 27.2.2002. A further detailed guideline for empanelling of hospitals is enclosed (Annexure-G).
11. As per para 2.2.3 of BSNLMRS, working employees may be allowed advance towards expenses on hospitalization where long duration treatment or major operation becomes necessary. A Performa for 'Application for Medical Advance' is appended at 'Annexure E'.
12. As per para 2.2.2 of BSNLMRS, the reimbursement will be allowed for treatment in non-recognized hospitals in emergency cases with the approval of CGM for field office employee and concerned Director for C.O. employees. The amount of reimbursement will be restricted to the CGHS rates applicable at Delhi.
13. As per para 4.0 of BSNLMRS, the facility for Direct payment to the Hospitals by the company (i.e. BSNL) has to be arranged. All CGMs of Territorial Circles may make suitable arrangement with approved hospitals accordingly and notify to their employees & C.O. In C.O. this is presently being negotiated with approved hospitals.
14. An Employee should intimate regarding his/her serious illness needing hospitalization to the sections dealing with Medical Policy implementation. A letter of authorization shall be issued to the hospital concerned so that necessary

help is extended by the hospital. A sample of such authorization letter is enclosed for guidance (Annexure-F).

15. All claims for reimbursement should be submitted latest by six months from the completion of the treatment. Claims submitted beyond this period are liable to be rejected.
16. The existing arrangement of AMA will be discontinued henceforth.
17. In case of any doubt regarding any provision of the BSNLMRS, the matter may be referred to Corporate Office for clarification.
18. In case the spouse of any BSNL employee is employed in any other organization, and the BSNL employee concerned wants to avail of BSNLMRS facility for his/her spouse or other dependent family members, a certificate has to be submitted by the spouse regarding non-availing of any medical facility for self/family from his/her organization.
19. Any misuse of the BSNLMRS facility would attract stringent action against employee(s) under the CCS(CCA) Rules or the rules notified by BSNL from time to time..
20. CGMs in circle office are their own controlling officer for the purpose of BSNLMRS.
21. The retired employees have the option to choose the Circle/SSA of their choice for availing the facility under BSNLMRS. Any change in the Circle/SSA subsequently will be changed on a request from the retired employee by this office.

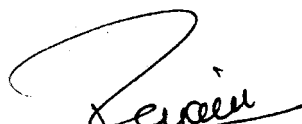
Hindi version will follow.

Encls: As above.

  
(Amarjit Bhatia)  
Asstt. Dir. Gen.(Admn.)

Copy to

1. All Chief General Managers, BSNL.
2. PS to CMD, BSNL.
3. PPS/PS to all Directors of BSNL Board.
4. All Sr. DDsG/DDsG, BSNL CO.
5. DG, P&T Audit.
6. Admn.I /L&A/PAT/CSS Sections of BSNL CO.
7. All recognized Associations/Unions of BSNL.

  
(Rajeev Kr. Jain)  
Section Officer (Admn.)

**ANNEXURE – A**

**MEDICAL FACILITY FOR BSNL EMPLOYEES**

**OPTION FORM**

1. Name of Employee:
2. Designation:
3. Place of Posting:
4. Options for availing Medical Policy:
  - i) CGHS
  - ii) BSNLMRS
5. Details of CGHS Card, if any
  - i) CGHS Card No.:

I, do, hereby certify that I have gone through the notification of BSNL Medical Reimbursement Scheme and am exercising my option after satisfying myself about various provisions under BSNLMRS.

(Signature of Employee)

*Re*

**ANNEXURE - B**

**BHARAT SANCHAR NIGAM LTD.**

**BSNL EMPLOYEES MEDICAL REIMBURSEMENT SCHEME**  
**REGISTRATION FORM**

1. Name of Employee: 2. Designation:  
3. Place of posting: 4. Staff No.: 5. Basic Pay:  
6. Telephone: (Office)----- (Residence) -----  
7. Details of Family Members:

Sl. No.	Name	Date of Birth	Relationship with employee	Blood Group (If available)

8. Details of chronic disease, if any: a)-----  
b)-----  
c)-----  
d)-----

9. Options for outdoor treatment (under BSNLMRS):-  
(tick any one of i), ii) or iii) )

- i) Outdoor/Domiciliary treatment from RMPs: Reimbursement against vouchers (as per Para 2.1.0).  
ii) Outdoor/Domiciliary treatment: Entitlement without voucher(as per Para 2.1.1)  
ii) Outdoor/Domiciliary treatment from P&T Dispensaries (as per Para 2.1.2)

**Declaration:**

I hereby declare that above mentioned members of my family are fully dependent on me, i.e. their income from all sources does not exceed Rs. 1500/- per month. If the above information is found to be false at any time, company can take action against me as per rules or as deemed fit.

(Signature of Employee)

**FOR OFFICE USE ONLY**

REGISTRATION NO. ISSUED-----

CARD ISSUED : YES/NO on -----

(Date of issue)

Signature of Issuing Authority

**ANNEXURE - C**

**MEDICAL REIMBURSEMENT CLAIM FORM FOR OUTDOOR TREATMENT**

1. Name of Employee: 2. Designation:  
3. Reg. No.:  
4. Salary (Basic Pay + DA)/Pension (as on 01-04-----):  
5. Place of Duty: 6. Name of Patient:  
7. Relationship with Employee: 8. Age:  
9. Reimbursement claimed under:  
(Tick relevant box)  
• Treatment from RMP (as per Para 2.1.0)   
• Treatment from P&T Dispensary (as per Para 2.1.2)   
10. Nature of illness:  
11. Name of Doctor/Hospital:  
12. Details of claim:  
(attach prescription, vouchers, etc. in duplicate)

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	Voucher No.
	Amount
• Consultation:	
• Diagnostics/Tests:	
• Medicines:	
• Appliances:	
• Special treatment (e.g. Physiotherapy, Yoga etc.):	
• Others:	
	Total: _____
	(Rupees-----)

**Declaration:**

I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is wholly dependent on me.

(Signature of Employee)

**ANNEXURE – D**

**MEDICAL REIMBURSEMENT CLAIM FORM FOR INDOOR  
TREATMENT**

1. Name of Employee:
2. Designation:
3. Reg. No.:
4. Salary (Basic Pay + DA)/Pension (as on 01-04-----):
5. Place of Duty:
6. Name of Patient:
7. Relationship with Employee:
8. Age:
9. Nature of illness:
10. Name of Doctor/Hospital:
11. Period of treatment: From ----- To-----  
(Certificate issued by the Medical Officer in-charge of the hospital as per enclosed proforma is to be attached)
12. Details of claim:  
(attach prescription, vouchers, etc. in duplicate)

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	Voucher No.	Amount
• Consultation:		
• Diagnostics/Tests:		
• Medicines/Injections:		
• Appliances:		
• Room Rent:		
• Charges for Nurses:		
• Others:		
		Total: _____
		(Rupees-----)

**Declaration:**

I, hereby declare that the statements given in application are true to the best of my knowledge and belief and that the person for which medical expenses are incurred is fully dependent on me.

(Signature of Employee)

**CERTIFICATE FOR HOSPITALIZATION**

Annex - D-I

(To be completed in the case of patients who are admitted to hospital for treatment)

Certificate granted to Mrs./Mr./Miss \_\_\_\_\_,  
husband/wife/son/daughter/mother/father \_\_\_\_\_ of  
Mrs./Mr. \_\_\_\_\_, employed in the office of  
\_\_\_\_\_, BSNL.

**PART 'A'**

I, Dr. \_\_\_\_\_ hereby certify:

- (a) that the patient was admitted to hospital on \_\_\_\_\_
- (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.
- (c) that the patient is/was suffering from \_\_\_\_\_ and is/was under treatment from \_\_\_\_\_ to \_\_\_\_\_
- (d) that the X-ray, laboratory tests, etc. for which an expenditure of Rs. \_\_\_\_\_ was incurred were necessary and were undertaken on my advice at \_\_\_\_\_ (name of hospital or laboratory);

Signature and Designation of the  
Medical Officer In-charge of the  
case at the hospital



**ANNEXURE – E**

**BHARAT SANCHAR NIGAM LTD.**

**APPLICATION FORM FOR MEDICAL ADVANCE**

1. Name of Patient
2. Relationship with Employee:
3. Age:
4. Name of Disease (for which hospitalization is required):
5. Name of Hospital:
6. Name of Employee:
7. Designation:
8. Salary (Basic + DA)/Pension:
9. Basic Pay:
10. Estimated cost of treatment  
(Enclose original copy of hospital's estimate)
11. Amount of Advance required for treatment:

Signature:  
Designation:  
Section:  
Tel. No.:

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**ANNEXURE - F**



***Bharat Sanchar Nigam Ltd.  
(A Govt. of India Enterprise)  
Corporate Office  
Statesman House, B-148 Barakhamba Road,  
New Delhi - 110 001.***

No.  
Date:

**AUTHORISATION LETTER FOR TREATMENT IN  
HOSPITAL**

This is to certify that Sh./Smt.----- (Name of the patient), Age----- is the Husband/Wife/Son/Daughter/Mother/Father of Sh./Smt.-----, an employee of BSNL. He/She may be admitted in (Hospital's Name) ----- as per his/her room entitlement, i.e. -----.

He/She may be charged as per agreed rates with BSNL.  
Bills as per agreed rates may be sent to this office for payment.

(Signature of the Competent Authority)

**ANNEXURE – G**

**RELEVANT INFORMATION FOR PROCESSING CASE FOR  
EMPANELMENT OF HOSPITALS**

1. Name of the Hospital
  - a) Whether the hospital is recognized by the State Government for treatment of its employees and if so, a copy of the order thereof.
2. Location/Address of the hospital
  - Map of the city/town showing the exact location of the hospital to be attached.
3. (i) Name (s) of Government hospital (s)/recognized hospital (s) (within a radius of 4 Kms.).
  - (ii) Clinical facilities available in the above hospitals.
4. Strength of BSNL employees and their family members likely to be benefited.
5. INDOOR FACILITIES.
  - i) No. of beds in the hospital – specialty-wise.
  - ii) General Wards
    - Number
    - Size
    - No. of beds in each ward
    - Amenities provided
    - Rates
  - iii) Semi private Wards
    - Number
    - Size
    - Rates
  - iv) Private Wards
    - Number
    - Size
    - No. of beds in each ward
    - Amenities provided
    - Rates

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- v) Operation Theatres
  - Number
  - Size
  - Equipments
  - Rates
  
- vi) Diagnostic Facilities
  - Pathological
  - Radiological
  - Others
  - Rates
  
- vii) Details of the Blood bank
  
- viii) ICU & ICCU Facilities
  
- 6. EMERGENCY AND TRAUMA SERVICES
  - i) No. of Ambulances available
  - ii) No. of doctors available with particular reference to Emergency and Trauma Services
  
- 7. SPECIALISED SERVICES
  - i) Nature of Specialised Services
  - ii) Name of specialists with qualifications and field of specialisation
  - ii) Facilities of clinical investigations
  
- 8. Facilities for Family Planning Services
  
- 9. DOCTORS
  - i) List of doctors available and their bio-date.
  - ii) Terms and conditions of the employment of doctors with particular reference to
    - Pay
    - Duration of the appointment whether part time or full time
  - iii) Private practice whether allowed or not
  - iv) The names of hospitals or clinical centers the said doctors are associated with
  
- 10. PARA – MEDICAL STAFF  
Conditions of employment of para-medical personnel
  - Whole time/part time
  - Pay
  - Duration for which appointed
  
- 11. Average O.P.D. attendance during last one year.

12. Schedule of charges (Schedule of charges of nearby Govt. hospitals and one nearby recognized hospital are to be furnished for comparison purpose).
13. Particulars of casualty services in the hospital
14. Percentage of free treatment in OPD and also reserved beds for poor patients.
15. Inventory of equipments
16. Residential physicians and residential surgeons.
17.
  - i) Doctors-patients ratio
  - ii) Doctors-nurses ratio
  - iii) Nurses-patients ratio
  - iv) Bed occupancy rate at present.
18.
  - i) Types of operations carried out and their number, speciality-wise during last one year.
  - ii) Isolation Ward/bed for communicable diseases like Diphtheria, Cholera, Measles, Chicken Pox, Tuberculosis, Tetanus, Polio etc.
19. Apart from the clinical amenities, availability of other amenities like the size of the rooms, no. of beds in each room, no. of toilets available to each room, provision for electrical amenities like fans/ACs/Coolers (in Private/Semi-Private & General Wards)/lifts in the building etc.
20.
  - i) Annual Budget.
  - ii) Kind of drugs being stored.
  - iii) Man-power.

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