

ALL INDIA INSTITUTE OF MEDICAL SCIENCES
ANSARI NAGAR, NEW DELHI - 110029
(HOSPITAL STORES)

Date: 20.08.2026

Subject: Check list of documents/information required from EHS beneficiaries for reimbursement claims at AIIMS.

It is brought to the notice of all AIIMS employees and EHS beneficiaries that to ensure smooth and efficient processing of reimbursement claims, the standard checklist of required documents has been updated. All EHS claimants are requested to submit the reimbursement claims along with the following required mandatory details/information and documents:-

1. Mandatory Details Required in Application Form

Particular	Required Details / Information
Application and Billing Details	Date of Application, Bill Number, Total Claim Amount
Beneficiary / Employee Details	Employee Name, Beneficiary Name, EHS Number, Salary Code / Employee ID, Contact Number

2. Checklist of Required Documents by Reimbursement Type

Sr. No.	Reimbursement Type	Document/Information Required for EHS Reimbursement
1.	Emergency Treatment	1. Application addressed to Medical Superintendent describing the Emergency Circumstances of treatment 2. Reimbursement claim form 3. Emergency Certificate from Hospital (Original) 4. Bills (All in Original) with sign and stamp of treating doctor/hospital to be enclosed (GST registered) 5. Discharge Summary 6. Employee's documents: Copy of EHS Book (Employee/Patient), I-Card, Salary Slip or Pension Pay Order / PPO (In case of retired staff)
2.	Hearing AID	1. Application addressed to Medical Superintendent 2. Undertaking regarding last date of purchase of hearing aid (if already taken through AIIMS) 3. Reimbursement claim form 4. Photocopy of O.P.D. Card of ENT where Hearing AID is prescribed 5. Audiometry report (In Original) with sign and stamp of treating doctor mentioning type of hearing aid advised (BTE or RIC/CIC) 6. Indent Slip mentioning item name and remarks of store that item is not available (Original) with name, sign & stamp 7. Bill in Original (GST registered) 8. Copy of EHS Book (Employee/Patient), I-Card, Salary Slip or Pension Pay Order (PPO)

3.	Maternity Treatment	1. Application addressed to Medical Superintendent 2. Reimbursement claim form 3. Discharge Summary Mother and child (Both) 4. Bills (All in Original) with sign and stamp of treating doctor/Hospital to be enclosed (GST registered) 5. Leave Memo, in case bills submitted after maternity leave 6. Copy of EHS Book (Employee/Patient), I-Card, Salary Slip
4.	Investigation / Test	1. Reimbursement claim form 2. Photocopy of O.P.D. card with comments of the treating doctor/department that particular "Investigation/Test is not available at AIIMS" 3. Bills in Original (GST registered) 4. In case of NIPT/Dual marker test, bills may be duly verified by faculty of Genetic Division 5. Copy of EHS Book (Employee/Patient), I-Card, Salary Slip or Pension Pay Order (PPO)
5.	Surgical Store Related Items	1. Reimbursement claim form 2. Photocopy of O.P.D. Card where item is prescribed 3. Indent Slip mentioning item name and remarks of Store that item is not available (Original) 4. Bills in Original (GST registered) 5. Copy of EHS Book (Employee/Patient), I-Card, Salary Slip or Pension Pay Order (PPO)
6.	Ambulance Bill	1. Reimbursement claim form 2. Non-availability slip for ambulance, verified by Duty Officer 3. Original Invoice 4. Discharge Summary 5. Copy of EHS Book (Employee/Patient), I-Card, Salary Slip or Pension Pay Order (PPO)

* All documents are to be self-attested by the claimant.

Note: Reimbursement claim should be submitted within 6 months from the date of discharge from the hospital or the completion of treatment.

Encl:

1. Reimbursement claim form (Annexure – I)
2. Sample copy of Emergency Certificate (Annexure – II)

20/08/26

Office In-charge, EHS
AIIMS, New Delhi
 सहायक आयुर्विज्ञान प्रशासन विभाग/Dept. of Hospital Administration
 अखिल भारतीय आयुर्विज्ञान संस्थान/AIIMS
 अंसारी नगर, नई दिल्ली/Ansari Nagar, N.D.-110029

अखिल भारतीय आयुर्विज्ञान संस्थान / ALL INDIA INSTITUTE OF MEDICAL SCIENCES

अन्सारी नगर, नई दिल्ली / Ansari Nagar, New Delhi-110029

क्र. सं./बुक सं. /Sl. No. / Book No. _____

दिनांक/Date _____

नोट :- कृपया फॉर्म में सभी कॉलम भरें। / NOTE : PLEASE FILL ALL THE COLUMNS IN THE FORM.

फार्मासिस्ट / प्रभारी क. स्वा. यो फार्मसी / वार्ड की संस्तुति पर निम्नलिखित दवाएं डिस्पेंसरी / वार्ड में उपलब्ध न होने के कारण बाजार से खरीदी गई थी। ये दवाइयाँ डॉ. द्वारा लिखी गई थी।
ओ. पी. डी. / वार्ड द्वारा लिखी गई थी।

On the recommendation of the Pharmacist / Incharge E.H.S. Pharmacy / Ward the following Medicines were purchased from the market which were prescribed by Dr.
O.P.D./Ward as it was not available in the dispensary/ward.

क्र. सं./Sl. No.	दवाई / सर्जिकल सामान का नाम/Name of Medicine / Surgical Item	मात्रा/Qty.
1.		
2.		
3.		

कुल रु. के कैश मीमो संलग्न हैं।

Cash Memo/ Memos for Total Rs. is / are enclosed.

रोगी का नाम/Name of the Patient _____ ई. एच. एस. पहचान पत्र सं./E.H.S.I. Card No. _____

(हस्ताक्षर/Signature) : _____

ई. एच. एस. दावेदार का नाम/Name of E.H.S. Claimant : _____

पदनाम/Designation : _____

फार्मासिस्ट/सिस्टर प्रभारी, वार्ड के

रबड की मोहर सहित हस्ताक्षर

Signature of the Pharmacist/

Sister Incharge, Ward

with Rubber Stamp

वेतन बिल/कोड सं. का विवरण/Details of Salary Bills / Code No. : _____

पता/Address : _____ खाता सं./A/c. No. : _____

बिल का सत्यापन किया गया। रु. (रुपये) की स्वीकृति एवं अनुमोदन हेतु प्रस्तुत।
Verified the bill. Submitted for sanction and approval for Rs. (Rupees)

प्रभारी अधिकारी द्वारा सत्यापित/Verified by Officer Incharge

सक्षम प्राधिकारी द्वारा स्वीकृत/Sanction by Competent Authority

प्रेषित : रोकड़/लेखा परीक्षा/लेखा अधिकारी, ह. व. कें. / रा. प्र. कें. / सं. रो. कें. अ. / अनुसंधान विभाग को वेतन बिल के द्वारा भुगतान हेतु।

Forwarded to : Cash/Audit/A.O., C.N.C./R.P.C./I.R.C.H./Scheme Cell for making payment through Salary bills.

(नोट : ई.एच.एस. फोटो पहचान-पत्र, नीला टोकन कार्ड एवं नुस्खा इंडेंट कापी और सत्यापित बिलों की प्रतिलिपियों के संलग्न किए बगैर प्रतिपूर्ति हेतु अनुरोध स्वीकार नहीं किया जाएगा।) (Note :- No request for Reimbursement will be entertained without enclosing copy of the E.H.S. Photo I. Card, Blue Token Card & Prescription Indent Copy and verified Bills)

(काउंटर फॉइल / Counter Foil)

क्र. सं./बुक सं. /Sl. No. / Book No. _____ दिनांक/Date _____

कैश मीमो सं रु. (रुपये) हेतु /Cash Memo No. for Rs. _____

रोगी का नाम /Name of Patient _____ ई.एच.एस. पहचान पत्र सं./E.H.S.I. Card No. _____

फार्मासिस्ट/सिस्टर प्रभारी, वार्ड के

ई. एच. एस. दावेदार का नाम/Name of the E.H.S. Claimant _____



HOSPITAL & MEDICAL RESEARCH CENTRE



05 Aug 2022 - 04 Aug 2026
Since Aug 5, 2010

Date 6/6/2026

(EMERGENCY CERTIFICATE)

TO WHOMSO EVER IT MAY CONCERN

This is to certify that Mr. / Mrs. [REDACTED] Age [REDACTED]

Male/ Female, W/o, D/o, s/o, F/o, H/o [REDACTED]

R/o [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED]

is admitted in this hospital as an emergency case of Ovarian Torsion at 12:24

AM/PM, vide I.D. No. 26/302634 with the diagnosis / chief complaints

of Extreme pain in left side of lower abdomen
& vomiting (3-4 episodes) on 2/6/2026

..... was admitted from 2/6/2026
to 4/6/2026

SENIOR CONSULTANT IN [REDACTED]
[REDACTED] & MEDICAL RESEARCH CENTRE

Dr. [REDACTED]
Emergency & Trauma
DMC Regn. No. [REDACTED]

Family