GOVERNMENT OF NAGALAND
NAGALAND HEALTH PROTECTION SOCIETY
HEALTH AND FAMILY WELFARE DEPARTMENT
NAGALAND: KOHIMA

No/NHPS/26-CR/509/2024/2114 Dated Kohima the 07th Aug, 2025

OFFICE MEMORANDUM

Subject: Submission of Emergency Medical Reimbursement Claim Form for Treatment at Non-Empanelled Hospitals under CMHIS (EP)

In continuation of Government Notification No. HFW-45/B/6/CMHIS/2022 dated 28th March 2024 regarding claim reimbursement under emergency category, all CMHIS (EP) beneficiaries who have availed medical treatment at non-empanelled hospitals due to a medical emergency or when the specific procedure is not available in any empanelled hospital with the approval of the State Medical Board are hereby directed to submit the *Emergency Medical Reimbursement Claim Form* (Annexure 1) along with all requisite supporting documents.

This is applicable for claims being submitted under the emergency clause of the CMHIS scheme for Employees and Pensioners.

Annexure 1: *Emergency Medical Reimbursement Claim Form*

Sd/-

(THAVASEELAN K) IAS
CEO, Nagaland Health Protection Society

No/NHPS/26-CR/509/2024/2114 Dated Kohima the 07th Aug, 2025

Copy to:

1. Office Copy

07/08/25

(DR. KIKAMEREN LONGKUMER)
Jt. CEO, Nagaland Health Protection Society

Annexure: 1

< Hospital Letterhead >

EMERGENCY MEDICAL REIMBURSEMENT CLAIM FORM

(For Treatment Undertaken at Non-Empanelled Hospital for CMHIS Employees and Pensioners)

PART A: BENEFICIARY AND TREATMENT DETAILS

(To Be Filled By The Beneficiary / Claimant)

1. Beneficiary Details

- Name of Employee/Pensioner: _____
- AYUSHMAN CMHIS ID : _____
- CMHIS HHID: _____
- Name of Patient (if different from Employee/Pensioner):
  _____
- Age / Gender: _____
- Mobile Number: _____
- Address: _____

2. Hospitalisation Details

- Name of Hospital: _____
- Hospital Address: _____
- Date & Time of Admission: _____
- Date & Time of Discharge: _____
- Nature of Emergency (tick one or more):
  - ☐ Accident / Trauma
  - ☐ Acute Medical Condition
  - ☐ Life-threatening Situation
  - ☐ Maternal Emergency
  - ☐ Other (specify): _____

3. Reason for Seeking Treatment at Non-Empanelled Hospital

_____

_____

4. Documents Submitted (tick as applicable):

☐ Discharge Summary
☐ Final Hospital Bill with Cost Breakup
☐ Diagnostic Reports & Prescriptions
☐ Proof of Payment (Receipt / Invoice)

☐ Beneficiary ID Proof

5. Declaration by Beneficiary / Claimant

I hereby declare that the information furnished above is true to the best of my knowledge and the treatment was undertaken under emergency circumstances. I understand that providing false information may lead to rejection of the claim.

Signature of Beneficiary / Claimant: _____
Name: _____
Date: _____

PART B: EMERGENCY CERTIFICATION FROM HOSPITAL

(To Be Filled By The Treating Hospital / Doctor)

1. Hospital Information

- Name of Hospital: _____
- Registration No. (if any): _____
- Hospital Address: _____
- Contact Number: _____
- Email ID (if available): _____

2. Emergency Certification

This is to certify that Mr./Ms. _____ was admitted to our hospital on _____ at _____ hrs with the following emergency condition(s):

☐ Accident / Trauma
☐ Acute Medical Emergency
☐ Life-threatening Condition
☐ Maternal Emergency
☐ Other (please specify): _____

Brief Description of Emergency Condition:

_____

_____

Was the condition life-threatening or requiring immediate intervention?

☐ Yes
☐ No

Could the patient have been safely shifted to a empanelled facility at the time of admission?

☐ No, due to critical condition
☐ No, due to unavailability of transport / distance
☐ Yes (please explain why not referred): _____

3. Certification by Treating Doctor / Hospital Authority

I hereby confirm that the patient was treated under genuine emergency circumstances and the information provided is accurate to the best of my knowledge.

Name of Treating Doctor: _____

Qualification: _____

Medical Registration Number: _____

Signature: _____

Seal & Date: _____

INSTRUCTIONS TO CLAIMANT

- Submit this form along with supporting documents within the prescribed period (usually 30 days from date of discharge).
- Incomplete or unsupported claims may be subject to rejection.
- Additional documents or clarification may be requested during claim processing.