

No.D.12019/5/2024-MSHCS/MUHCS
GOVERNMENT OF MIZORAM
MIZORAM STATE HEALTH CARE SOCIETY



Dated: Aizawl, the 10th July, 2025

CIRCULAR

Finance Department OM vide No.D.12015/1/2025-FEA/GIA dated 4th June, 2025 in a tarlan angin, GIA funded State owned Societies, Boards and other GIA funded State organizations and State funded Co-terminus employees ten Mizoram Universal HealthCare Scheme (MUHCS) an hman theih dan tur leh Finance Department OM No.D.12015/1/2025-FEA/CSS dated 6th June, 2025 in CSS employees tana MUHCS hman theih dan tur alo tarlan tawh angin, empanelled hospital-a thawktu ten damlo chu MUHCS beneficiary a ni ngei em tih leh Scheme hnuaiah cashless treatment dawng thei a ni em tih an lo finfiah hmasak na turin damdawiin luh dawnah GIA leh CSS category hmanga MUHCS zawmtute chuan a hnuaia document tarlan tehi an ken ngei ngei a ngai -

- 1) GIA Employees tan:** Finance Department-in GIA employee tana 'Details of Family' format a siam From A emaw Form B (*sample enclosed*)
- 2) CSS Employees tan:** Finance Department-in CSS employee tana 'Details of Family' format a siam (*sample enclosed*)

Empanelled hospital-te hman turin MUHCS beneficiary category milin 'color patterned' Claim Form siam alo ni tawh a, GIA employee leh CSS employee tan pawh color patterned Claim Form hman siam a ni. GIA employee tan '**Blue**', CSS employee tan '**Purple**' hman tur a ni ang (*sample enclosed*). Claim Form hnunglamah hian damdawiin ten claim kan thehluh ruala documents thehluh tel ngei ngei ngai tarlan a ni baw.

Sd/- Dr. BIAKTHANSANGI

Chief Executive Officer,
Mizoram State Health Care Society
-cum- State Health Agency, AB PM-JAY, Mizoram
Dinhtar, Aizawl

Memo No.: D.12019/5/2024-MSHCS/MUHCS

Dated Aizawl, the 10th July, 2025

Copy to:

- 1) All empanelled hospitals*
- 2) All District Coordinators, MSHCS*

21.7/25

Chief Executive Officer,
Mizoram State Health Care Society
-cum- State Health Agency, AB PM-JAY, Mizoram
Dinhtar, Aizawl

(Revised Version)

DETAILS OF FAMILY

Form-A : For GIA Employees currently enjoying Medical Reimbursement

{See Section – 4(l) of CS(MA) Rules, 1944}

(For use in MUHCS)

Name of Government Servant : _____

Designation : _____ Pay Matrix Level : _____

Employee No. (as generated by IFMIS, if available) : _____

Date of Birth : _____ Date of Appointment : _____

Lump sum contribution per year : _____

Ceiling fixed for one year : _____

Details of the family members as on : _____

Sl. No.	Names of the family members	Date of Birth	Relationship with the Govt. Servant	Document submitted	Remarks of the Controlling Officer
1	2	3	4	5	6
1					
2					
3					
4					
5					
6					
...					

I certify that the above declaration made by me is fully updated and correct.

Date.....

Signature of Govt. Servant
Mobile No.: _____

DECLARATION OF THE CONTROLLING AUTHORITY

After careful checking of the documents submitted by the Government Servant. I satisfy myself that the above _____ (number of the members) persons are truly the family members of _____ for the purpose of CS(MA) Rules, 1944

Date.....

Signature of the Controlling Officer
(with seal)

See over leaf for eligibility conditions for Family Members for the purpose of CS(MA) Rules, 1944 and documents to be submitted in support of the declaration.

(Revised Version)

DETAILS OF FAMILY

Form-B : For GIA Employees who have not enjoyed Medical Reimbursement

{See Section – 4(I) of CS(MA) Rules, 1944}

(For use in MUHCS)

Name of Government Servant : _____

Designation : _____ Pay Matrix Level : _____

Employee No. (as generated by IFMIS, if available) : _____

Date of Birth : _____ Date of Appointment : _____

Lump sum contribution per year : _____

Ceiling fixed for one year : _____

Details of the family members as on : _____

Sl. No.	Names of the family members	Date of Birth	Relationship with the Govt. Servant	Document submitted	Remarks of the Controlling Officer
1	2	3	4	5	6
1					
2					
3					
4					
5					
6					
...					

I certify that the above declaration made by me is fully updated and correct.

Date.....

Signature of Govt. Servant

Mobile No.:_____

DECLARATION OF THE CONTROLLING AUTHORITY

After careful checking of the documents submitted by the Government Servant. I satisfy myself that the above _____ (number of the members) persons are truly the family members of _____ for the purpose of CS(MA) Rules, 1944

Date.....

Signature of the Controlling Officer

(with seal)

See over leaf for eligibility conditions for Family Members for the purpose of CS(MA) Rules, 1944 and documents to be submitted in support of the declaration.

DETAILS OF FAMILY
(For CSS Employees)
(To be used in MUHCS)

Name of CSS Employee : _____ Name of CSS : _____

Designation : _____ Date of Appointment : _____

Employee No.(as generated by IFMIS, if available) : _____

Aadhaar No.(if available): _____

Date of Birth : _____

Ration Card No.* : _____

Salary Category (tick one):

Below ₹30,000/-	☐	₹30,000/- to ₹50,000/-	☐
₹50,001/- to ₹60,000/-	☐	Above ₹60,000/-	☐

Lump sum contribution per year : _____

The details of my family members as on _/ _/ _ as per Ration Card is as below:-
 (CSS Employee details to be filled in Sl. No. 1 and Relationship may be written as SELF)

Sl.No.	Name of the family members	Relationship with the CSS Employee	Aadhaar No. (if available)
1			
2			
3			
4			
5			
6			
...			

* Attested photo copy of family Ration Card to be enclosed.

I certify that the above declaration made by me is fully as per my family Ration Card.

Date.....

Signature of the CSS Employee

Mobile No.:_____

DECLARATION OF THE CONTROLLING AUTHORITY

After careful checking of the documents submitted by the CSS Employee. I satisfy myself that the above _____ (number of the members) persons are truly the family members as per the family Ration Card of _____ for the purpose of medical treatments under MUHCS.

Date.....

Signature of the Controlling Officer
 (with seal)



MIZORAM UNIVERSAL HEALTHCARE SCHEME
2025-2026
OFFLINE CLAIM FORM

CASE ID
(For MSHCS Office Use only)

For GIA Employees and their Dependent Family Members

(Hawrawppui veka dahkhah tur a ni a,
dahkhah ngai zawng zawngte hmaih awm lova dahkhah vek tur)

Date:

GIA Employee Details

Name of GIA Employee : _____

Office where employed : _____

Employee Unique ID : _____

Pay Level : _____ Mobile: _____

Whether GIA Employee currently enjoys Medical Reimbursement: Yes ☐ No ☐

Patient Details

Name of Patient : _____

Age : _____ Sex: _____

Relation with CSS Employee: _____

Aadhaar No. :

Claim Details

Case : Medical ☐ Surgical ☐ Day Care ☐

Name of Hospital : _____

Date & Time of Admission : _____

Date & Time of Discharge : _____

Provisional Diagnosis : _____

Final Diagnosis : _____

Booked Package : _____

Booked Package Code : _____

Claim Amount: ₹ _____ + Accomodation: ₹ _____ = Total: ₹ _____

(As per package rate)

Seal & Signature of MO

Mandatory documents to be submitted-

1. Case taking form/Admission note (Original Copies)
2. All continuation sheets/indoor case papers (Original Copies)
3. Treatment chart (from DOA to DOD, Original Copies)
4. Vitals chart (from DOA to DOD, Original Copies)
5. OT Note in case of Surgical Package (Original Copy)
6. Investigation reports supporting the diagnosis and booked package (Original Copies)
7. Accommodation charge details/breakup (Original Copy)
8. Discharge Summary (Original Copy)
9. Death Summary in case of death (Original Copy)
10. GIA Details of Family (Form A or B) for use in MUHCS (Xerox copy)





MIZORAM UNIVERSAL HEALTHCARE SCHEME
2025-2026
OFFLINE CLAIM FORM

CASE ID
(For MSHCS Office Use only)

For CSS Employees and their Family Members

(Hawrawppui veka dahkhah tur a ni a,
dahkhah ngai zawng zawngte hmaih awm lova dahkhah vek tur)

Date:

CSS Employee Details

Name of CSS Employee : _____

Name of CSS : _____

Employee Unique ID : _____ Mobile: _____

Salary Category :

Below ₹30,000/-		₹30,000/- to ₹50,000/-	
₹50,001/- to ₹60,000/-		Above ₹60,000/-	

Patient Details

Name of Patient : _____

Age : _____ Sex: _____

Relation with CSS Employee: _____

Aadhaar No. :

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Claim Details

Case :

Medical		Surgical		Day Care	
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Name of Hospital : _____

Date & Time of Admission : _____

Date & Time of Discharge : _____

Provisional Diagnosis : _____

Final Diagnosis : _____

Booked Package : _____

Booked Package Code : _____

Claim Amount: ₹ _____ + Accomodation: ₹ _____ = Total: ₹ _____

(As per package rate)

Seal & Signature of MO

Mandatory documents to be submitted-

1. Case taking form/Admission note (Original Copies)
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7. Accommodation charge details/breakup (Original Copy)
8. Discharge Summary (Original Copy)
9. Death Summary in case of death (Original Copy)
10. CSS Details of Family to be used in MUHCS (Xerox copy)

