राष्ट्रीय हथकरघा विकास निगम लिमिटेड,

(भारत सरकार का उपक्रम, वस्त्र मंत्रालय),

ए-2 से ए-5, सेक्टर-2, उद्योग मार्ग, नोएडा – 201301, जिला – गौतम बुद्ध नगर (उ.प्र.)

NHDC/OO/2026/162 दिनांक: 12.11.2026

कार्यालय आदेश

विषय: NHDC के सेवानिवृत्त कर्मियों द्वारा बाह्य रोगी विभाग (ओपीडी) चिकित्सा प्रतिपूर्ति दावों (Medical Reimbursement Claims) को प्रस्तुत करने के संबंध में।

राष्ट्रीय हथकरघा विकास निगम लिमिटेड (एनएचडीसी) के समस्त सेवानिवृत्त कर्मियों को सूचित किया जाता है कि अब से ओपीडी के अंतर्गत किए गए सभी चिकित्सा व्यय की प्रतिपूर्ति के दावे सीधे नेशनल इंश्योरेंस कंपनी लिमिटेड (National Insurance Company Limited) को प्रस्तुत किए जाएंगे, जैसा कि वर्तमान में अस्पताल में भर्ती (Hospitalization) संबंधी दावों के लिए किया जा रहा है।

चिकित्सा प्रतिपूर्ति सुविधा के अंतर्गत निम्नलिखित ओपीडी व्यय के दावे, लागू बीमा पॉलिसी के नियमों एवं शर्तों के अधीन प्रस्तुत किए जा सकेंगे:

1. डॉक्टर से परामर्श (Doctor Consultations): सामान्य चिकित्सकों (General Practitioners) अथवा विशेषज्ञ चिकित्सकों (Specialist Doctors) को परामर्श हेतु भुगतान की गई फीस।
2. नैदानिक जांच (Diagnostic Tests): ओपीडी के अंतर्गत कराई गई प्रयोगशाला जांच (Laboratory Investigations), अन्य नैदानिक जांच तथा रेडियोलॉजी रिपोर्ट से संबंधित व्यय।
3. दवाइयों के बिल (Pharmacy Bills): उपचार कर रहे चिकित्सक द्वारा निर्धारित दवाइयों एवं दवाइयों की खरीद पर किया गया व्यय।

ओपीडी चिकित्सा प्रतिपूर्ति दावे प्रस्तुत करने हेतु सेवानिवृत्त कर्मचारी Genins की वेबसाइट/मोबाइल एप्लिकेशन से प्रतिपूर्ति दावा प्रोफार्मा (Reimbursement Claim Form) डाउनलोड कर सकते हैं। उक्त प्रोफार्मा निम्नलिखित लिंक पर उपलब्ध है:

https://www.geninsindia.com/download/forms

सभी सेवानिवृत्त कर्मियों से अनुरोध किया जाता है कि वे विधिवत भरे हुए दावा प्रपत्र (Claim Form) के साथ संबंधित बिल एवं आवश्यक सहायक दस्तावेज सीधे नेशनल इंश्योरेंस कंपनी लिमिटेड के TPA को निम्नलिखित पते पर भेजें:

Address:- GENINS INDIA INSURANCE TPA Ltd.
SHOP NO. 101/104 LGF ANARKALI COMPLEX
JHANDEWALAN EXTENSION,
NEW DELHI-110055

भविष्य में किसी भी OPD बीजक का निगम द्वारा सीधे समायोजन नहीं किया जाएगा।

ओपीडी दावों को प्रस्तुत करने एवं उनके निस्तारण के संबंध में किसी भी प्रकार की जानकारी अथवा सहायता के लिए सेवानिवृत्त कर्मी निम्नलिखित नामित संपर्क अधिकारी (Single Point of Contact – SPOC) से संपर्क कर सकते हैं:

- नाम: श्री अजय सिंह/Ajay Singh
- संपर्क नंबर/Contact No.: 9899946139
- ई-मेल/Email: claims_delhi@geninsindia.com

सभी संबंधित सेवानिवृत्त कर्मियों से अनुरोध है कि वे उपर्युक्त निर्देशों को संज्ञान में लें तथा ओपीडी चिकित्सा प्रतिपूर्ति दावों को प्रस्तुत करने हेतु संशोधित प्रक्रिया का पालन करें।

पॉलिसी की वैधता अवधि दिनांक 01-08-2026 से 31-07-2027 तक है। अतः केवल उक्त अवधि से संबंधित बीजकों का ही समायोजन/भुगतान किया जा सकेगा। इसलिए आपसे अनुरोध है कि पॉलिसी की वैधता अवधि के अनुसार ही बीजक प्रेषित करना सुनिश्चित करें।

यह आदेश सक्षम प्राधिकारी के अनुमोदन से जारी किया जाता है।

12/11/26

(उप महाप्रबंधक - मानव संसाधन)

सेवा में:

एनएचडीसी के समस्त सेवानिवृत्त कर्मी।

प्रतिलिपि सूचनार्थ एवं आवश्यक कार्रवाई हेतु:

1. प्रबंध निदेशक सेल
2. अधिशासी निदेशक (वित्त)
3. सतर्कता विभाग
4. महाप्रबंधक (वित्त एवं लेखा)
5. उप महाप्रबंधक (वाणिज्य)
6. सूचना प्रौद्योगिकी विभाग– एनएचडीसी की वेबसाइट पर अपलोड करने हेतु।
7. कार्यालय आदेश फ़ाइल
8. सूचना पट्ट

राष्ट्रीय हथकरघा विकास निगम लिमिटेड,

(भारत सरकार का उपक्रम, वस्त्र मंत्रालय),

ए-2 से ए-5, सेक्टर-2, उद्योग मार्ग, नोएडा – 201301, जिला – गौतम बुद्ध नगर (उ.प्र.)

NHDC/OO/2026/162 **Date: 12.11.2026**

OFFICE ORDER

Subject: Submission of OPD Medical Reimbursement Claims by Retired Employees of NHDC – Reg.

It is hereby informed to all retired employees of NHDC that, henceforth, all claims pertaining to Outpatient Department (OPD) medical expenses shall be submitted directly to National Insurance Company Limited, in the same manner as the existing procedure for hospitalization claims.

The following OPD expenses shall be eligible for submission under the medical reimbursement facility, subject to the applicable policy terms and conditions:

1. Doctor Consultations: Consultation fees paid to General Practitioners (GPs) or Specialist Doctors.
2. Diagnostic Tests: Expenses incurred on outpatient laboratory investigations, diagnostic tests and radiology reports.
3. Pharmacy Bills: Cost of medicines and drugs prescribed by the attending medical practitioner.

For submission of OPD reimbursement claims, retired employees are advised to download the Reimbursement Claim Form from the Genins website/mobile application using the following link:

https://www.geninsindia.com/download/forms

All retired employees are requested to submit their duly filled-in claim forms, along with the relevant supporting documents and bills, directly to TPA of National Insurance Company Limited.

Address: - Genins India Insurance TPA Ltd. |
SHOP NO. 101/104 LGF ANARKALI COMPLEX
JHANDEWALAN EXTENSION,
NEW DELHI-110055

In future, no OPD bills shall be settled directly by the Corporation (Head Office).

For any clarification or assistance regarding submission and processing of OPD claims, retired employees may contact the designated Single Point of Contact (SPOC), whose details are given below:

- **Name: Sh. Ajay Singh**
- **Contact No.: 9899946139**
- **Email ID: claims_delhi@geninsindia.com**

All concerned retired employees are requested to take note of the above instructions and follow the revised procedure for submission of OPD medical reimbursement claims.

The validity period of the policy is from 01-08-2026 to 31-07-2027. Accordingly, only bills pertaining to this period shall be eligible for settlement/payment. You are therefore requested to submit the bills strictly in accordance with the policy validity period.

This issues with the approval of the Competent Authority.

12/11/26

(DGM - HR)
NHDC

To:
All Retired Employees of NHDC

Copy to:

1. MD Cell
2. ED (Finance)
3. Vigilance Department
4. GM (Finance)
5. DGM (Comm.) / DGM (HR)
6. IT Department (For Uploading on NHDC Website)
7. Office Order File
8. Notice Board

Enclosed. OPD form

Genins India Insurance TPA Ltd.
Third Party Administrator in Health Insurance
ISO 9001:2015 Certified Company

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A
TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

IRDAI REGISTRATION NO. 020

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: ____ b) Sl. No/ Certificate No: ____

c) Company/ TPA ID No: ____

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address : ____

City: ____ State: ____

Pin Code: ____ Phone No: ____ Email ID : ____

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No b) Date of commencement of first Insurance without break: DD MM YY

c) If yes, company name: ____ Policy No. ____

Sum Insured (Rs.) ____ d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: MM YY

Diagnosis: ____ e) Previously covered by any other Mediclaim / Health insurance : ☐ Yes ☐ No

f) If yes, Company Name ____

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male ☐ Female ☐ c) Age: years YY months MM d) Date of Birth: DD MM YY

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify) ____

f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify) ____

g) Address (if different from above): ____

City: ____ State: ____

Pin Code: ____ Phone No: ____ E-mail ID: ____

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: ____

b) Room Category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐ d) Date of Injury / Date Disease first detected /Date of Delivery: DD MM YY

e) Date of Admission: DD MM YY f) Time: HH : MM g) Date of Discharge: DD MM YY h) Time: HH : MM

i) If Injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ i. If Medico legal: ☐ Yes ☐ No

ii. Reported to police: ☐ Yes ☐ No iii. MLC Report & Police FIR attached: ☐ Yes ☐ No j) System of Medicine: ____

SECTION E

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs. ____ ii. Hospitalization Expenses: Rs. ____

iii. Post-hospitalization Expenses: Rs. ____ iv. Health-Check up Cost: Rs. ____

v. Ambulance Charges: Rs. ____ vi. Others (code): ____ Rs. ____

Total Rs. ____

vii. Pre-hospitalization period: days ____ viii. Post-hospitalization period: days ____

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: Rs. ____ ii. Surgical Cash: Rs. ____

iii. Critical Illness Benefit: Rs. ____ iv. Convalescence: Rs. ____

v. Pre/Post hospitalization Lump sum benefit: Rs. ____ vi. Others: ____ Rs. ____

Total Rs. ____

Claim Documents Submitted- Check List:

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		DD MM YY		Hospital Main Bill	
2.		DD MM YY		Pre-hospitalization Bills:___Nos	
3.		DD MM YY		Post-hospitalization Bills:___Nos	
4.		DD MM YY		Pharmacy Bills	
5.		DD MM YY			
6.		DD MM YY			
7.		DD MM YY			
8.		DD MM YY			
9.		DD MM YY			
10		DD MM YY			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

c) Bank Name and Branch: ____

d) Cheque/ DD Payable details: ____ e) IFSC Code: ____

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date: D D M M Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		