PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED (IRDA License No. 006)

[formerly known as PARAMOUNT HEALTH SERVICES (TPA) PVT.LTD]

Plot no.A-442, Road No-28,M.I.D.0 Industrial Area, Wagale Estate, Ram Nagar, Vitthal Rukmani Mandir, Thane (W), Mumbai, Pin Code — 400 604

CLAIM ACKNOWLEDGMENT SHEET

Name of Insurer :		**PHS ID :**	
Insured Name :		**Employee No :**	
Patient Name :		**Mobile No :**	
Policy No :		**Phone (STD) :**	
Name of Corporate:			
Type of Claim (To be ticked) :	Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	**E-Mail ID of primary insured :**	

CLAIM DOCUMENT CHECK LIST

Sr. No	Description	Document Status(Y/N)	Remarks
1	IRDA Claim Form duly signed by the Insured & Hospital		
	Part-A: Duly signed by the insured with Claimed amount ,Mobile number & Email ID along with PHS ID		
	Part-B: Duly signed and stamped by hospital		
	Declaration form duly signed & stamped by the hospital in case treatment taken is under PPN/GIPSA hospitals.		
1.a	Policy Declaration Form duly signed by the Insured & Hospital hospitals.		
2	In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same.		
3	Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the AccountHolder Printed on the Cheque Leaf.		
4	ID Proof of Employee / Primary Insured- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID) . If Claim is above 1 lakh- PAN is mandatory with address Proof		
5	ID Proof of Patient- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID)		
6	Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care Treatment) / Death Summary (in Case of Death Claim)		
6.a	Copy of the Legal heir certificate (if the claim is for the death of the principle insured)		
6.b	Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)		
7	Policy Copy (**if individual policy)**		
8	64VB Compliance Certificate (**If individual policy)**		
9	Original Final Hospital bill with cost wise breakup of each Item		
10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)		
10.a	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip as received from the Vendor		
11	Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL		
12	Original bills, original Payment Receipts and investigation / Laboratory Reports		
13	Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions.		
14	Original copy of First Consultation letter and subsequent Prescriptions.		
15	Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not falls in GIPSA/PPN)		
16	**OTHER DOCUMENTS**		
16.a	Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)		
16.b	Original Sonography Report in case of Maternity Claim		
16.c	Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract Claim		
16.d	Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA)		
16.e	A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases)		
16.f	In case of claims where the insured has submitted documents to another insurance cofTPA, he needs to submit attested Photocopies of all the documents along with detailed claim settlement letter from the TPA and any unpaid bills and receipt for the same in originals.		

Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital

Claim Submitted by:		**Mobile No.**	
Date of Claim Submission:	DD /MM/YYYY HH:MM	**PHS Executive Name:**	
Claim Submitted at:	PHS - (Location) / Help Des!	**Signature:**	

Important Points to Remember:-

1. Please mark either **V** **or** x against respective check box
2. Date of File Received will be considered as next working day for Claim Files picked up at Help Desk
3. Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital
4. The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our document recovery team will contact you on receipt of your claim documents by us
5. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

CLAIM FORM FOR HEALTH INSURANCE POLICIES

OTHER THAN TRAVEL AND PERSONAL ACCIDENT

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

(Guidance for filling claim form - **Part A** is available on our website: www.royalsundaram.in)

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

PART A

DETAILS OF PRIMARY INSURED (PROPOSER) — **(TO BE FILLED IN BY THE INSURED)**

SECTION A

a) Policy No. | b) Sl. No./ Certificate No.

c) Membership No./ TPA ID No.

d) Name

e) Address

City | State

MOST IMPORTANT

Pin Code | Land Line (with STD Code)

PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.

Mobile No. | Email ID

Alternate Email ID

DETAILS OF INSURANCE HISTORY (MANDATORY)

SECTION B

a) Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

b) If yes, Company Name

Policy No. | c) Date of commencement of first Insurance without break (D D M M Y Y Y Y)

d) Sum Insured (Rs.) | e) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No f) Date (D D M M Y Y Y Y)

g) Diagnosis

DETAILS OF INSURED PERSON HOSPITALIZED

SECTION C

a) Name

b) Gender ☐ Male ☐ Female c) Age (Y Y) Years (M M) Months d) Date of Birth (D D M M Y Y Y Y)

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

f) Communication Address

City | State

Pin Code | Land Line (with STD Code)

g) Occupation ☐ Doctor ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____

h) Name of the Employer

i) Address of the Employer

DETAILS OF HOSPITALIZATION

SECTION D

a) Name & Address of Hospital where Admitted

City | State

Pin Code | Land Mark

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ 3 or more beds per room ☐ Any other category, Pls specify _____

c) Hospitalization due to ☐ Injury ☐ Illness ☐ Maternity

d) Date of Injury/Date Disease first detected (D D M M Y Y Y Y)

e) Date of Admission (D D M M Y Y Y Y) Time (H H : M M)

f) Date of Discharge (D D M M Y Y Y Y) Time (H H : M M)

g) In case of maternity, 1 Date of Delivery (D D M M Y Y Y Y) 2 Gravida Status _____

h) If Injury, give cause ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

1. If Medico legal ☐ Yes ☐ No 2. Reported to police ☐ Yes ☐ No 3. MLC Report & Police FIR attached ☐ Yes ☐ No

i) System of Medicine _____

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	2. Hospitalization Expenses	Rs.
3. Post-hospitalization Expenses	Rs.	4. Health-Check up Cost	Rs.
5. Ambulance Charges	Rs.	6. Others	Rs.
		Total amount claimed	Rs.

b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash	Rs.	2. Surgical Cash	Rs.
3. Critical Illness Benefit	Rs.	4. Convalescence	Rs.
5. Pre/Post hospitalization Lump sum benefit:	Rs.	6. Others_____	Rs.
No of days (Pre Hospitalisation)_____		**Total amount claimed**	Rs.
No of days (Post Hospitalisation)_____			

SECTION E

Check List of Claim Documents to be submitted (In original)* - Please tick relevant box
(For Hospital Cash benefit, photocopies of claim documents are acceptable)

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill ☐ Hospital Break-up Bill
- ☐ Advance and final bill payment receipt **(Mandatory)**
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT/MRI/USG/HPE/ECG)
- ☐ Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital
- ☐ Test report and prescription relating to first consultation for the illness
- ☐ KYC document (Address proof, ID proof only for claims exceeding Rs. 1 Lakh)
- ☐ FIR/MLC in case of accident injury and English translation of the same if it is in any other language
- ☐ Cancelled Cheque leaf of the bank account held in the name of the primary insured **(Mandatory)**
- ☐ Operation Theatre Notes
- ☐ Original Death Summary (Wherever applicable)

***Please retain copy of complete set of claim documents for your records**

DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y Y Y		Hospital Main Bill	
2		D D M M Y Y Y Y		Pre-hospitalization Bills: (Nos____)	
3		D D M M Y Y Y Y		Post-hospitalization Bills: (Nos____)	
4		D D M M Y Y Y Y		Pharmacy Bills: (Nos_____)	
5		D D M M Y Y Y Y			

Hospital Main Bill Payment Receipts only

Receipt No	Date	Amount	Please Tick Relevant Box
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt

Note : Please attach separate sheet if necessary

SECTION F

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN b) Account Number

c) Bank Name and Branch

d) IFSC Code

SECTION G

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.

Date D D M M Y Y Y Y Place

Signature of the Primary Insured

SECTION H

Royal Sundaram General Insurance Co. Limited
(Formerly known as Royal Sundaram Alliance Insurance Company Limited)
Corporate Office: Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.
IRDAI Registration No.102 | CIN: U67200TN2000PLC045611

1860 425 0000 | **customer.services@royalsundaram.in** | **www.royalsundaram.in**

PR16144/AUG16

To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

CLAIM FORM – PART B

TO BE FILLED IN BY THE HOSPITAL

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

(Guidance for filling claim form- **Part B** is available on our website: www.royalsundaram.in)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital

b) Hospital ID
(For Office use only)

c) Type of Hospital ☐ Network ☐ Non Network (If non network fill section D)

d) Name of the treating Doctor

e) Qualification

f) Registration No. with State Code

g) Phone

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number

c) Gender ☐ Male ☐ Female d) Age Y Y Years M M Months e) Date of Birth D D M M Y Y Y Y

f) Type of Admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

g) Date of Admission D D M M Y Y Y Y Time H H : M M

h) Date of Discharge D D M M Y Y Y Y Time H H : M M

i) If Maternity

1.Date of Delivery D D M M Y Y Y Y 2.Gravida Status _____

j) Status at time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

SECTION C

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis			M M Y Y Y Y
2. Additional Diagnosis			M M Y Y Y Y
3. Co-morbidities			M M Y Y Y Y
4. Co-morbidities			M M Y Y Y Y
	ICD 10 PCS Codes		
1. Procedure(1)			
2. Procedure(2)			
3. Procedure(3)			
4. Details of any other Procedure			

a) Whether preauthorisation obtained ☐ Yes ☐ No. If yes, Preauthorisation No._____

b) If Authorisation by network hospital not obtained, please give reason_____

c) Hospitalization due to Injury ☐ Yes ☐ No If Yes, give cause _____

1. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No

If Yes, details of tests conducted_____

3. If Medico legal ☐ Yes ☐ No 4. Reported to Police ☐ Yes ☐ No 5. FIR No.

6. If not reported to police, give reason_____

d) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation) D D M M Y Y Y Y

e) Please give previous medical history of the patient

f) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

		Say Yes/No	Duration in Year	Duration in Month
1.	Bronchial Asthma			
2.	Chronic Obstructive Pulmonary disease			
3.	Hypertension			
4.	Diabetes			
5.	Heart ailment			
6.	Arthritis of any kind			
7.	Cerebro vascular attack			
8.	Seizure disorder			
9.	Renal/Kidney Disorder			
10.	Congenital conditions			
11.	Developmental anomalies			
12.	Any other			

g) Is the ailment a complication / sequel of a pre-existing disease or condition? If Yes , please give details

h) History of alcoholism ☐ Yes ☐ No
If yes : No of years _____
Quantity consumed per day _____

i) History of Smoking/ Tobacco chewing ☐ Yes ☐ No
If yes : No of years _____
Units consumed per day _____

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City State

d) Hospital PAN e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT ☐ Yes ☐ No 2. ICU ☐ Yes ☐ No 3. Round the clock Doctor/Nurses ☐ Yes ☐ No
4. Maintains daily record of patients ☐ Yes ☐ No
5. Others _____

SECTION D

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, insured's right to claim under this policy shall be for feited.

Date D D M M Y Y Y Y Place

Signature and Seal of the Hospital Authority

SECTION E

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Authorization Letter (Mandatory)

Date:

From:

To:

The Manager/ Medical Superintendent,
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:_____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____(Third admission) in _____Hospital

I consent and authorize M/s Royal Sundaram General Insurance Co. Limited and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and/or meet/obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalization dated ..... to .....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient

Paramount Health
Your link to good health

POLICY DECLARATION FORM

Date:……

Name of the Hospital :……

Address:……

PATIENT NAME (BLOCK LETTERS):…… AGE/SEX :……

Mobile No of Patient:……

Date of Admission:…… Date of Discharge:……

Undertaking by the Patient regarding Heath Insurance Policy
(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I have not declared about any health insurance policy, at the time of Hospital admission.
(मैं सुचित करता हूं कि अस्पताल में उपचार के दौरान मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है ।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I have declared about the health insurance policy, at the time of Hospital admission.
(मैं सुचित करता हूं कि अस्पताल में उपचार के दौरान मेरे पास स्वास्थ्य बीमा पॉलिसी है,

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Undertaking by the Hospital

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Patient did not declare any health insurance coverage, at the time of hospital admission. Hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है, अस्पताल में भर्ती के समय । इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)

- Patient declared health insurance coverage, at the time of hospital admission. But out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है, अस्पताल में भर्ती के समय । लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature: ……

Name of the Hospital Representative & Hospital Seal