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.

Bajaj General Insurance Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
Email id: careforyou@bajajgeneral.com
Toll free no:1800-209-5858 020-30305858

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(To be filled in block letters)

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

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No: b) Sl. No/Certificate No:
c) Company TPA ID No: d) Customer ID:
e) Company Name: f) Employee No:
g) Name:
h) 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
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: D D M M Y Y Y Y
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 of the Patient:
b) Health ID card no of the Patient:
c) Gender: Male ☐ Female ☐ d) Age: years months e) Date of Birth D D M M Y Y Y Y
f) Relationship of Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)
g) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)
h) Address (if different from above)
City: State: Pin Code:
I) Phone No: J) Email 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) Hospitalisation due to: Injury ☐ Illness ☐ Maternity ☐
d) Date of Injury/Date Disease first detected/Date of Delivery: D D M M Y Y Y Y
e) Date of admission D D M M Y Y Y Y f) Time: H H M M g) Date of Discharge D D M M Y Y Y Y h) Time: H H M M
I) Name of treating doctor Diagnosis
j) 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 and Police FIR attached: Yes ☐ No ☐ j) System of Medicine

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

I. Pre-Hospitalisation Expenses:	Rs.	ii. Hospitalisation Expenses	Rs.
iii. Post-Hospitalisation Expenses:	Rs.	iv. Health checkup cost	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code)	Rs.
		Total	Rs.
vii. Pre-Hospitalisation period:	days	viii. Post Hospitalisation period:	days

b) Claim for Domiciliary Hospitalisation: 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 hospitalisation lump sum benefit	Rs.	vi. Others	Rs.
		Total	Rs.

Claim Documents Submitted – Check List

- ☐ Claim Form Duly Signed
- ☐ Copy of claim intimation if any
- ☐ Original Hospital Main Bill
- ☐ Original Hospital Breakup Bill
- ☐ Original Hospital Bill Payment Receipt
- ☐ Original Hospital Discharge SummaryPharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Original Doctor's Prescriptions
- ☐ Original Doctors request for investigation reports (including CT/MRI/USG/HPE)
- ☐ Others
- ☐ Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook.

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Hospitalisation Main Bill	
2		D D M M Y Y		Pre-Hospitalisation Bills:__Nos	
3		D D M M Y Y		Post-Hospitalisation Bills:__Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

a) Name of the Account Holder (As per Bank Account):_____

b) Account no (As appearing in the cheque book):

c) Bank Name :_____

d) Branch Name & Address:_____:

e) Account Type : Saving ☐ Current ☐ Cash Credit ☐

f) MICR No. g)IFSC Code:

h) PAN: i) Cheque / DD Payable Details:

DECLARATION

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 Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who ha s 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 Insured

SECTION E

SECTION F

SECTION G

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
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 a s allotted by IRDA and printed in TPA documents.
g) Name	Enter the full name of the policyholder	Surname, First name, Middle name
h) 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 Policy No. Sum Insured	Enter the full name of the insurance company Enter the policy number Enter the total sum insured a s per the policy	Name of the organization in full As allotted by the insurance company In rupees
d) Have you been Hospitalized in the last four years since inception of the contract? Date Diagnosis	Indicate whether hospitalized in the last four years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use dd-mm-yy format 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 of the Patient	Enter the full name of the patient	Surname, First name, Middle name
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
f) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
h) Address	Enter the full postal address	Include Street, City and Pin Code
i) Phone No	Enter the phone number of patient	Include STD code with telephon number
j) 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 i) If Injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached	Use hh:mm format Tick the right option Tick Yes or No Tick Yes or No 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 a s 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
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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
i) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/	Name of the individual/
g) IFSC Code	DD should be made out to Enter the IFSC code of the bank branch	organization in full FSC code of the bank branch in full
h) PAN	Enter the permanent account number	As allotted by the Income Tax department
SECTION H - DECLARATION BY THE INSURED Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Bajaj General Insurance Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
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Toll free no:1800-209-5858
020-30305858

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(To be filled in block letters)

CLAIM FORM- PART B

TO BE FILLED IN BY THE HOSPITAL
The issue of this form is not to be taken as admission of liability
Please include the original preauthorization request form in lieu of PART-A

(To be filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital : _____

b) Hospital ID : _____ c) Type of hospital : Network ☐ Non-Network ☐ (If non-network fill section E)

d) Name of treating doctor: _____

e) Qualification: _____ f) Registration No with State Code _____ g) Phone No: _____

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient : _____

b) IP registration Number : _____ c) Gender: Male ☐ Female ☐ d) Age : Years ☐☐ Months: ☐☐ e) Date of birth: D D M M Y Y

f) Date of admission: D D M M Y Y g) Time : H H M M h) Date of discharge : D D M M Y Y i) Time: H H M M

j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of delivery D D M M Y Y ii)Gravida Status: ☐☐

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased: ☐ m) Total claimed Amount: ☐☐☐☐☐☐

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i) Primary Diagnosis:	☐☐☐☐		i) Procedure 1:	☐☐☐☐	
ii) Additional Diagnosis:	☐☐☐☐		ii) Procedure 2:	☐☐☐☐	
iii) Co-morbidities :	☐☐☐☐		iii) Procedure 3:	☐☐☐☐	
iv) Co-morbidities :	☐☐☐☐		iv) Details of Procedure:		

d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number: ☐☐☐☐☐☐☐☐☐☐

f) If authorization by network hospital no obtained, give reason: _____

g) Hospitalization due to injury: Yes ☐ No ☐ i)If Yes give cause: Self-inflicted: ☐ Road Traffic Accident: ☐ Substance abuse/ alcohol consumption: ☐

ii) If injury due to Substance abuse/alcohol consumption, Test conducted to establish this: Yes ☐ No ☐ (If Yes attach reports) iii)Medico Legal: Yes ☐ No ☐

iv)Reported to Police: Yes ☐ No ☐ v) FIR no: _____ vi) if not reported to police give reason: _____

SECTION D

CLAIM DOCUMENTS -CHECK LIST

- ☐ Claim form duly signed
- ☐ Original Pre-Authorization request
- ☐ Copy of Pre-Authorization letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break up bill
- ☐ Ingestion reports
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

a) Address of hospital _____

City: _____ State: _____ Pin Code: _____ Phone No: _____ c) Registration no with State Code: _____

d) Hospital PAN: _____ e) Number of Inpatient beds: ☐☐☐ Facilities available in hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐

iii) Others: _____

SECTION F

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

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

Date : D D M M Y Y

Place : _____

Signature and Seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
	SECTION A - DETAILS OF HOSPITAL	
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of the hospital	As allocated by TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
d) Name of Treating doctor	Enter the name of treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of treating doctor	abbreviations of educational qualifications
f) Registration No with state code	Enter the registration no of treating doctor along with state code	As allocated by the medical council of India
g) Phone No	Enter the phone no of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of the patient	Enter the name of hospital	Name of hospital in full
b) IP Registration number	Enter the insurance provide registration number	As allocated by the insurance provide
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter date of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m)Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open tex
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/ alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
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
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police,give reason	Enter reason for not reporting to police	Open Text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

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