

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.O 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)		
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 co/TPA, 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:-

- Please mark either **V** or **x** against respective check box
- Date of File Received will be considered as next working day for Claim Files picked up at Help Desk
- Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital
- 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
- Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App
- 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
- Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.

Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | E: customercare@cholams.murugappa.com | website: www.cholainsurance.com

IRDA Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977

REACH US THROUGH WHATSAPP  **7305234433**

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED

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

- IN-PATIENT HOSPITALIZATION CLAIM
 CRITICAL ILLNESS
 HOSPITAL DAILY CASH
 HEALTH CHECK UP
 PRE AND POST CLAIM
 OUT-PATIENT CLAIM
 OTHERS

SECTION A – DETAILS OF PRIMARY INSURED

a. Policy No		Membership No
b. Certificate No		
c. Company / TPA ID No		
d. Name (In Block Letters)		
e. Address (In Block Letters)		
Phone No		Email ID
Primary Insured Occupation		
WhatsApp No	<input checked="" type="checkbox"/> I hereby provide my consent for Chola MS to communicate through Whatsapp	

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/YYYY
c. If Yes, Company Name	
Policy No.	
Sum Insured	
d. Have you been hospitalized in the last four years since inception of the contract	YES / NO Date: MM/YYYY
Diagnosis	
e. Previously covered by any other Mediclaim/Health insurance	YES / NO
f. If yes, Company Name	

SECTION C – DETAILS OF INSURED PERSON HOSPITALISED

a. Name			
b. Patient ABHA ID No.			
c. Relationship (Self/spouse/Child/Father/Mother/Other)	d. Date of Birth	e. Age ____ Yrs	____ months
f. Address (If different than above)			
g. Gender	Male / Female	h. Occupation	Service/Self-employed/ Homemaker/student/ Retired/ Others
i. Telephone No	j. Mobile No		
k. E-mail ID, if any			

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SECTION D - DETAILS OF HOSPITALISATION

a. Name of the Hospital where admitted			
b. Room Category occupied		Daycare/Single Occupancy/Twin Sharing/3 or more beds per room	
c. Hospitalization due to		Illness/Injury/Maternity	
d. Date of Injury/Date of disease first detected/ Date of delivery		DD/MM/YYYY	
e. Date of admission		DD/MM/YYYY	
f. Time admission		HH/MM	
g. Date of discharge		DD/MM/YYYY	
h. Time discharge		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	System of medicine
			Allopathic/Other systems of medicine

SECTION E - DETAILS OF CLAIM

a. Claim under Hospitalization Cover

i) In-Patient Hospitalization	YES / NO	ii) Pre-hospitalization Expenses	YES / NO
iii) Post-hospitalization Expenses	YES / NO	iv) Day Care Procedures	YES / NO
v) Domiciliary Hospitalization	YES / NO (if yes, please provide details in annexure)	vi) Road Ambulance Cover	YES / NO
vii) Critical illness	YES / NO	viii) Hospital Daily cash	YES / NO

b. Please tick the applicable Optional Cover claimed under Hospitalization Cover:

i) Hospital Cash	YES / NO	<<Please provide details>>
ii) Preventive Health Check Up	YES / NO	<<Please provide details>>
iii) Restore Benefit	YES / NO	<<Please provide details>>
iv) Alternative Treatment	YES / NO	<<Please provide details>>
v) Second Medical Opinion	YES / NO	<<Please provide details>>
vi) Double Restore Benefit	YES / NO	<<Please provide details>>
vii) Maternity Expenses	YES / NO	<<Please provide details>>
viii) Pre and Post Natal Expenses	YES / NO	<<Please provide details>>
ix) Infertility Cover	YES / NO	<<Please provide details>>
x) Accidental Death	YES / NO	<<Please provide details>>
xi) Permanent Disablement	YES / NO	<<Please provide details>>
xii) OPD Cover	YES / NO	<<Please provide details>>

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Claim Documents Submitted Check List: Hospitalization Claim		Check list of additional documents for Hospital Cash claims
<input type="checkbox"/> Duly filled and signed Claim Form	<input type="checkbox"/> Copy of intimation letter, if any	<input type="checkbox"/> Copy of discharge summary/discharge certificate along with time of admission and discharge for hospital cash benefit
<input type="checkbox"/> Hospital main bill	<input type="checkbox"/> Hospital bill break up	<input type="checkbox"/> First consultation letter from treating medical practitioner
<input type="checkbox"/> Hospital bill payment receipt	<input type="checkbox"/> Hospital discharge summary	<input type="checkbox"/> Certificate from treating medical practitioner, specifying the duration and aetiology
<input type="checkbox"/> Pharmacy bill	<input type="checkbox"/> Operation theatre notes	<input type="checkbox"/> MLC/FIR copy/ certificate regarding abuse of alcohol/intoxicating agent if applicable
<input type="checkbox"/> Investigation/diagnostic Reports with bills and payment receipt	<input type="checkbox"/> Doctors request for investigations	<input type="checkbox"/> Cancelled cheque copy with primary insured name printed or bank pass book copy with clear name/account no./ bank details
<input type="checkbox"/> ECG	<input type="checkbox"/> Prescriptions	
<input type="checkbox"/> Copy of the network provider's registration certificate	<input type="checkbox"/> MLC/FIR copy of applicable	
<input type="checkbox"/> KYC documents	<input type="checkbox"/> Implant stickers for all implants used during surgeries	

SECTION F – DETAILS OF BILLS ENCLOSED

Sno	Bill No	Date						Issued By	Towards	Amount (Rs)			
		D	D	M	M	Y	Y						
									Hospitalization bills				
									Pre-Hospitalization				
									Post-Hospitalization				
									Total Amount				

SECTION G – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a. Name of the primary insured	
b. Account number	
c. PAN number of the primary insured	
d. Bank name/ Branch	
e. Payee Name	
f. IFSC Code	

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g. *Attach a cancelled cheque pertaining to the same name of the account holder must be printed on the cheque	
h. MICR No	
i. CKYC of the primary insured	
Note: Enclose NEFT documents (Cancelled Cheque or Bank passbook clear copy) Please send all original documents along with duly filled and signed Claim form to the address mentioned on the Top of the Claim form Please mention as "Health Claim Documents" on the TOP of the envelop and mention the complete sender address along with mobile number without fail.	

SECTION H - 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.

I confirm that I had already received the Customer Information Sheet along with the Policy Document and all the terms and conditions of the Policy / claim process/ coverage and exclusions, amongst other terms, were understood by me.

Date: _____ Place: _____ Signature of Insured: _____



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GENERAL INSURANCE

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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
Please include the original pre-authorization request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a. Name of the Hospital where treated		b. Hospital Registration No	
c. Type of Hospital	Network	Non Network (If non network fill section E)	
d. Name of the treating Doctor		e. Qualification	
f. Registration No with state Code			
h. Health Facility Registry (HFR) ID		i. Healthcare Professionals Registry (HPR) ID	

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient		b) IP registration number	
c) Gender	Male/Female	d) Age	YY/MM
e) Date of birth	DD/MM/YYYY		
f) Date of admission	DD/MM/YYYY	g) Time of admission	HH/MM
h) Date of discharge	DD/MM/YYYY	i) Time of discharge	HH/MM
j) Type of admission	Emergency/Planned/Daycare/ Maternity	k) If Maternity	
l) Date of delivery	DD/MM/YYYY	ii) Gravida status	
l) Status at time of discharge	Discharged to Home Discharged to another Hospital Deceased	Total claimed amount	

SECTION C – DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis	Additional Diagnosis	Comorbidities	
Details of procedures done				
b) ICD 10 PCS	Procedure 1	Procedure 2	Procedure 3	
i) Pre-authorization obtained	Y/N	j) Pre-authorization No		
f) If authorization by network hospital not obtained, give reason				
g) Hospitalisation due to Injury	Y/N	i) If yes, give cause		
Self-inflicted?	Y/N	Road traffic accident	Y/N	Substance abuse / Alcohol consumption
ii) If Injury due to substance abuse / alcohol consumption, Test Conducted to establish this:	Y/N (If yes, attach reports	iii) Medico legal	Y/N	
iv) Reported to Police		v) FIR No		
vi) If not reported to police give reasons				

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SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECK-LIST

<input type="checkbox"/> Claim form duly filled and signed	<input type="checkbox"/> Investigation reports
<input type="checkbox"/> Pre authorization request	<input type="checkbox"/> CT/MRI/USG/HPE investigation report
<input type="checkbox"/> Copy of Pre-authorization approval letter	<input type="checkbox"/> Doctor's reference slip for investigation
<input type="checkbox"/> Copy of photo ID card of patient verified by Hospital	<input type="checkbox"/> ECG
<input type="checkbox"/> Hospital discharge summary	<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> Operation theatre notes	<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Hospital main bill	<input type="checkbox"/> Death summary from hospital where applicable
<input type="checkbox"/> Hospital break up bill	<input type="checkbox"/> Any other, PI specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital		b) Phone no	
c) Registration no with State Code		d) Hospital PAN	
e) No of In-patient beds		f) Facilities available in Hospital	
i) OT	Y/N	ii) ICU	Y/N
iii) Others			

SECTION F – DECLARATION BY HOSPITAL

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, our right to claim under this claim shall be forfeited.

Date: _____ Place: _____ Signature and seal of the Hospital Authority _____

CLAIM INTIMATION

Chola MS has arrangements with more than 11000 hospitals across India for availing of cashless facility. For availing benefit through reimbursement mode, advance intimation of at least 48 hours to Chola MS is required for planned hospitalisation and intimation within 24 hours for emergency hospitalisation. This would help us to pre-process your claim for a smooth experience. For more details call toll free number for Claim intimation at 1800-208-9100 or Mail: customercare@cholams.murugappa.com

EXCLUDED HOSPITALS

Expenses incurred towards the treatment in any hospital specifically excluded by Chola MS and disclosed in our website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses incurred for the treatment up to the stage of stabilization are payable but not the complete claim. Please refer our website www.cholainsurance.com for latest list of excluded hospitals and reach us at 1800-208-9100 or Mail: customercare@cholams.murugappa.com for any further clarification on this.

Please refer our website for latest list of Excluded Hospitals before Hospitalization, as we will not consider any claim from these hospitals. Please reach us at our tollfree number/mail ID given above for any further clarification on this.