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.C 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.		
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 Account Holder 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 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 Desk	**Signature:**	

Important Points to Remember:-

1. Please mark either **√** **or** **×** 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.

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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

SECTION A - DETAILS OF PRIMARY INSURED

a	Policy No	b	Sl. No/Certificate No:
c	Company/TPA ID No		
d	Name		
e	Address		
	City/State		Pincode
	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 D D M M Y Y Y Y	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
	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	Gender: Male / Female; c Age: Years Y Y Months M M; 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	Occupation: Service / Self-employed / Homemaker / Student / Retired / Other (Please Specify)
g	Address (if different from above)
h	Telephone No; i Mobile No
j	Email ID

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	Hospitalisation due to: Illness / Injury / Maternity; d Date of Injury/Date of 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	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-hospitalisation Expenses	Rs	ii	Hospitalisation Expenses	Rs
iii	Post-hospitalisation Expenses	Rs	iv	Health-Check up Cost	Rs
v	Ambulance Charges	Rs	vi	Others (code)	Rs
				Total	Rs
vii	Pre-hospitalisation Period	days	viii	Post - hospitalisation Period	days
a	Claim for Domiciliary Hospitalization	YES / No		(if yes, please provide details in annexure)	
b	Details of Lumpsum/cash benefit claimed:				
i	Hospital Daily Cash	Rs	ii	Surgical Cash	Rs
iii	Critical Illness Benefit	Rs	iv	Convalescence	Rs
v	Pre/Post hospitalisation lumpsum benefit	Rs	vi	Others	Rs
	Claim Documents Submitted - Check List:			**Total - Rs**	

☐ Claim Form duly filled and signed	☐ Copy of intimation letter, 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 Prescription
☐ Others	

SECTION - F DETAILS OF BILLS ENCLOSED

S. No .	Bill No .	Date						Issued by	Towards	Amount (Rs)
		D	D	M	M	Y	Y		Hospital Main Bill	
									Pre Hospitalisation Bills (…….Nos)	
									Post Hospitalisation Bills (……Nos)	
									Pharmacy Bills	

SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a	PAN		b	Account Number
c	Bank Name/Branch			
d	Payable details: Cheque/DD			
e	IFSC Code			*please attach a cancelled cheque pertaining to the same
f	MICR No			*please attach a cancelled cheque pertaining to the same

Note:
It is agreed that the Policyholder/Claimant will intimate in writing to DHFL General Insurance Limited. about any change in bank account details.

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.

Date: D D M M Y Y Y Y

Place:

Signature of Insured

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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) Sl. 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		

DATA ELEMENT	DESCRIPTION	FORMAT
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.		

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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 preauthorization request form in lieu of PART A

SECTION A - DETAILS OF HOSPITAL

a	Name of the Hospital						
b	Hospital ID		c	Type of Hospital	Network	Non Network	(If non network fill form section E)
d	Name of the treating Doctor						
e	Qualification	e	Registration No with state Code		g	Phone No:	

SECTION B - DETAILS OF PATIENT ADMITTED

a	Name of the patient								
b	IP Registration Number		c	Gender	Male	Female	d	Age	Years Y Y Months M M
e	Date of Birth	D D M M Y Y Y Y	f	Date of Admission	D D M M Y Y Y Y		g	Time of Admission	Y Y M M
h	Date of Discharge	D D M M Y Y Y Y	i	Time of Discharge	H H M M				
j	Type of Admission	Emergency	Planned	Daycare	Maternity	k	If Maternity	i	Date of Delivery D D M M Y Y Y Y
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 DIAGNISED (PRIMARY)

a		ICD 10 Code	Description	b		ICD 10 Code	Details of the Procedure
i	Primary Diagnosis			i	Procedure 1		
ii	Additional Diagnosis			ii	Procedure 2		
iii	Co-morbidities			iii	Procedure 3		

c	Present ailment is complication of PED?	YES	No	If Yes, specify details						
d	Pre-authorization obtained	YES	No	e	Pre-authorization No					
f	If authorization by network hospital not obtained, give reason									
g	Hospitalisation due to Injury	YES	No	i	If yes, give cause					
	Self inflicted?	YES	No	Road Traffic Accident	YES	No	Substance Abuse/Alcohol Consumption	YES	No	
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	YES No
vi	If not reported to Police give reasons									

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Original Pre authorization Request	☐ CT/MRI/USG/HPE investigation Report
☐ Copy of Pre-authorization approval Letter	☐ Doctor's reference slip for Investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital Discharge Summary	☐ Pharmacy Bills
☐ Operation Theatre Notes	☐ MLC Report & Police FIR
☐ Hospital Main Bill	☐ Original death summary from hospital where applicable
☐ Hospital break up Bill	☐ Any other, Pl specify

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill 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	YES	No	ii	ICU	YES No
iii	Others							

SECTION F - 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, 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/receipt for the purpose of this claim & that I will not be making any supplementary claim expect the pre/post hospitalization claim, if any,

Date: D D M M Y Y Y Y

Place:

Signature of the Insured

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale.

SECTION G - 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: D D M M Y Y Y Y

Place:

Treating Doctor Signature and seal of the Hospital Authority

by navi general insurance

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 hospital	As allocated by the 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 the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) 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
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
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		
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) Type of Admission	Indicate type of admission of patient	Tick the right option
j) 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
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
l) 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 text
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) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) 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		

DATA ELEMENT	DESCRIPTION	FORMAT
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 patient	As allocated by the Hospital
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 INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp.		