

| 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 Desl' | 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. | | | |

- b) Claim for
- i. Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)
 - ii. Day care: Yes No
 - iii. Extended care/ Inpatient rehabilitation: Yes No
- c) Details of lump sum/ cash benefit claimed:
- i. Hospital daily cash: ₹
 - ii. Maternity: ₹
 - iii. Critical illness/PA/Donor Expenses: ₹
 - iv. Convalescence: ₹
 - v. Pre/ Post hospitalization lump sum benefit: ₹
 - vi. Others: _____ ₹

A9. Details of the amount claimed

| Bill heads (as applicable) | Bill number | Bill date | Bills attached | Amount |
|--------------------------------------------------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Room rent | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Doctors consultation/Visit charges | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Investigation charges (Includes Radiology and Pathology reports) | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Surgeon and Asst. surgeon charges | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Anesthetist charges & Operation theatre charges | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Equipment charges/ Procedure charges | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Cost of implant (If any) | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Medicine charges (Includes ward and OT medicines and consumables) | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Pharmacy charges | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Taxes/ Surcharges/ Service charge | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Miscellaneous/ Other charges | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Pre hospitalization bills (If any) | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Post hospitalization bills (If any) | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Discount provided by hospital (If any) | | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents) | | | | ₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

MANDATORY: CENTRAL KYC (C-KYC) FORM REQUIRED ONLY FOR RETAIL/ INDIVIDUAL CUSTOMERS IF CLAIMING >₹ 1 LAKH

A10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the Yes/ No column below)

| Type of Document(s) - *Mandatory | Yes | No | Type of Document(s) - As Applicable | Yes | No |
|------------------------------------------------------------------------|--------------------------|--------------------------|---------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Claim form duly filled and signed* | <input type="checkbox"/> | <input type="checkbox"/> | 9. ICICI Lombard GIC Authorisation Letter | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Discharge summary* | <input type="checkbox"/> | <input type="checkbox"/> | 10. Implant name and invoice (if any) with implant sticker | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hospital bills, Final/ main hospital bill and other bills (if any)* | <input type="checkbox"/> | <input type="checkbox"/> | 11. Indoor Case Papers | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Hospital payment receipt & other receipts supporting bills* | <input type="checkbox"/> | <input type="checkbox"/> | 12. Prescription papers/ Consultation papers | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE) | <input type="checkbox"/> | <input type="checkbox"/> | 13. Others (details) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Medicine/ Pharmacy bills with doctors prescription* | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Age proof (Driving License/ PAN card/ Passport/ Aadhar copy)* | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 8. Part - C (For EFT/RTGS/ NEFT)* | <input type="checkbox"/> | <input type="checkbox"/> | 14. C-KYC FORM (Only for Retail/Individual customers, claiming >₹ 1 lakh) | <input type="checkbox"/> | <input type="checkbox"/> |

Please attach all the documents as per above serial number. Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

A11. Please provide the reason for delay in submitting the documents
(Post 30 days from Date of Discharge)

Provide Details

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and 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 and 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 and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any.

Date: / / Place: _____ Insured's Signature: _____

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

^ Your Claim details are just an SMS away. Please SMS <KEYWORD> to 57 57 58

* Cashless Status: <KEYWORD> is "ILHC AL <12-digit-AL-No.>" • Claim Status: <KEYWORD> is "ILHC CL <12-digit-CL-No.>" • Payment details: <KEYWORD> is "ILHC PAY <12-digit-Claim-No.>"

(AL No. & CL No. is the one you have received on your mobile no. after intimating us)

^ To view real time claim status, please click: <https://www.icicilombard.com/IL-Health-Care/Customer/ClaimStatus>

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

C1. Patient's Name: _____
(in respect of whom claim is made):

C2. Policy Number: _____

C3. Card No./ UHID No. _____

C4. Group/Company Name (for Group/Corporate policy holders): _____

C5. Claim Number (if allotted): _____ **C6. Mobile/ Contact No.:** _____

C7. Email: _____

C8. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide ANY ONE of the below documents of proposer/ policy holder-

- Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- Cancelled cheque copy
- Bank attested copy of Passbook with IFSC code

C9. Please provide the below details (all fields are compulsory)

- Proposer (policy holder)/ Employee name* (as per bank records): _____
- Proposer/ policy holder Bank account no.: _____
- Name of the bank: _____
- Branch name: _____
- Address of the bank: _____
- IFSC code no. of the bank: _____ (should be same as per the provided cheque leaflet)
- PAN no. of Proposer: _____

***Proposer/ Policy holder is the person who has paid premium for the policy.**

For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required.

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. may sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
11. These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
13. I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Account holder's Signature



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 Health 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 सूचित करता हूँ 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 सूचित करता हूँ 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 रीडंबर्समेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूंकि 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