

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:-			
1. Please mark either <b>V</b> or <b>x</b> 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 <a href="http://www.paramounttpa.com">www.paramounttpa.com</a> to check Online Claim Status or download Paramount Mobile App			
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer			
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.			

### TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability  
(To be filled in block letters)

DETAILS OF PRIMARY INSURED																									
a) Policy No.															b) Sl. No./Certificate No.										
c) Company/TPA ID No.																									
d) Name																									
e) Address																									
	City																								
	State																						Pin Code		
	Ph. No.																						Email ID		

DETAILS OF INSURANCE HISTORY																									
a) Currently covered by any other Mediclaim/Health Insurance															Yes		No								
b) If yes, Company Name																									
Policy No.															Sum Insured (₹)										
c) Date of commencement of first Insurance without break															DD / MM / YYYY										(Copies of Policies to be attached)
d) Have you been hospitalized in the last 4 years? (since inception of the contract)															Yes		No		Date	DD / MM / YYYY					
															Diagnosis										
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years															Yes		No								
f) If yes, Company Name																									

DETAILS OF INSURED PERSON HOSPITALIZED																								
a) Name																								
b) Gender	Male		Female		c) Age	years		months		d) Date of Birth	DD / MM / YYYY													
e) Relationship to Primary insured	Self		Spouse		Child		Father		Mother															
	Other		(Please Specify)																					
f) Occupation	Service		Self Employee		Homemaker		Student		Retired															
	Other		(Please Specify)																					
Address (if different from above)																								
	City																							
	State																						Pin Code	
	Ph. No.																						Email ID	

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) Hospitalization due to	Injury		Illness		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	HH	MM	g) Date of Discharge	DD / MM / YYYY		h) Time	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														
j) System of Medicine																									
k) Date of Surgery	DD / MM / YYYY		l) Claim Intimated											Yes	No										
i. Intimated to whom	SBU		Intermediaries		Call Centre		Health Claims Team																		
ii. Intimation No. & date														DD / MM / YYYY											
iii. If not Intimated, reason?																									

DETAILS OF CLAIM																			
a) Details of the treatment expenses claimed																			
i. Pre-hospitalization Expenses	₹									ii. Hospitalization Expenses	₹								
iii. Post-hospitalization expenses	₹									iv. Health-Check up Cost	₹								
v. Ambulance Charges	₹									vi. Others (code)									
vii. Pre-hospitalization period		days								<b>Total</b>	₹								
										viii. Post hospitalization period	days								
b) Claim for Domiciliary Hospitalization		Yes		No		(If yes, provide details in annexure)													
c) Details of Lump sum/cash benefit claimed																			
i. Hospital Daily Cash	₹									ii. Surgical Cash	₹								
iii. Critical Illness Benefit	₹									iv. Convalescence	₹								
v. Pre/Post hospitalization Lump sum benefit	₹									vi. Others									
										<b>Total</b>	₹								
<b>Claim Documents Submitted - Check List</b>										<b>Operation Theatre Notes</b>									
Claim Form Duly signed										ECG									
Copy of the claim intimation										Doctor's request for investigation									
Hospital Main Bill										Investigation Reports (CT/MRI/USG/HPE)									
Hospital Break - up Bill										Doctor's Prescriptions									
Hospital Bill Payment Receipt										Pre-Hosp. Bills									
Hospital Discharge Summary										Post-Hosp. Bills									
Pharmacy Bill										Others									

DETAILS OF BILLS ENCLOSED						
Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/Post-hospitalization)	Amount (₹)	
1		<u>DD / MM / YYYY</u>				
2		<u>DD / MM / YYYY</u>				
3		<u>DD / MM / YYYY</u>				
4		<u>DD / MM / YYYY</u>				
5		<u>DD / MM / YYYY</u>				
6		<u>DD / MM / YYYY</u>				
7		<u>DD / MM / YYYY</u>				
8		<u>DD / MM / YYYY</u>				
9		<u>DD / MM / YYYY</u>				
10		<u>DD / MM / YYYY</u>				

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details:

	Yes	No
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DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)																				
a) PAN										b) Account Number										
c) Bank Name and Branch																				
d) Cheque/DD Payable details										e) IFSC Code										

**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.

Place: \_\_\_\_\_ Date: DD/MM/YYYY

Signature of the Insured

- Important:**
- Please submit copy of valid Photo ID.
  - For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

## 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  
(To be filled in block letters)

Please include the original preauthorization request form in lieu of PART 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 the treating doctor													
e)	Qualification					f) Registration No. with State Code					g) Ph No.			

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	DD / MM / YYYY			f) Date of Admission	DD / MM / YYYY			g) Time	HH	MM		
h)	Date of Discharge	DD / MM / YYYY			i) Time	HH	MM						
j)	Type of Admission	Emergency		Planned		Day Care		Maternity					
k)	If Maternity	i. Date of Delivery		DD / MM / YYYY		ii. Gravida Status							
l)	Status at time of discharge	Discharge to home		Discharge to another hospital		Deceased							
m)	Total Claimed Amount	₹											

DETAILS OF AILMENT DIAGNOSED (PRIMARY)													
a)	ICD 10 Codes												
	Description												
i.	Primary Diagnosis												
ii.	Additional Diagnosis												
iii.	Co-morbidities												
iv.	Co-morbidities												
b)	ICD 10 Codes												
	Description												
i.	Procedure 1												
ii.	Procedure 2												
iii.	Procedure 3												
iv.	Details of Procedure												
c)	Present ailment is a complication of PED?	Yes	No	(If Yes, specify details)									
d)	Pre-authorization obtained	Yes	No										
e)	Pre-authorization Number												
f)	If authorization by network hospital not 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. If Medico legal	Yes	No	iv. Reported to Police		Yes	No	v. FIR No.					
	vi. If not reported to police give reason												

CLAIM DOCUMENTS SUBMITTED - CHECK LIST			
Claim Form duly signed		Operation Theatre notes	Doctor's reference slip for investigation
Original Pre-authorization request		Hospital main bill	ECG
Copy of the Pre-authorization approval letter		Hospital break-up bill	Pharmacy bills
Copy of photo ID card of patient verified by hospital		Investigation reports	MLC report & Police FIR
Hospital Discharge summary		CT/MR/USG/HPE investigation reports	Original death summary from hospital where applicable
Any other, please specify			

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)														
a)	Address of the Hospital													
	City													
	State											Pin Code		
b)	Phone No.						c) Registration No.							
	Date of Registration				DD / MM / YYYY				Expiry date of Registration				DD / MM / YYYY	
	Name of the Registering Authority													
d)	PAN						e) Number of Inpatient beds							
f)	Facilities available in the hospital						i. OT		Yes	No	ii. ICU		Yes	No
	iii. Others													

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

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below:

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- Has fully qualified nursing staff under its employment round the clock
- Has fully qualified doctor(s) in charge round the clock
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place: \_\_\_\_\_

Date: DD/MM/YYYY

Signature of  
Insured/Claimant

Signature and Seal of  
the Hospital Authority



## **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 सुचित 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 सुचित 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 रीडंबसमेंट/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