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.

ZURICH kotak General Insurance

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

FAMILY HEALTH PLAN (TPA) LTD **(To be filled in block letters)**

A) Name of Insurance Company:

B) Toll free phone number: 1800 266 4545

TO BE FILLED BY INSURED / PATIENT

A) Name of the Patient :_ _

B) Gender : Male : _ _ _ _ Female _ _ _ _ C) Age : Years :_ _ _ _ Month :_ _ _ _ D) Date of birth :_ _ _ _ _ _ _ _ _ _ _

E) Contact number: _ _ _ _ _ _ _ _ _ _ _ F) Contact number of attending relative: _ _ _ _ _ _ _ _ _ _ G) Insured card ID number: _ _ _ _ _ _ _ _ _ _ _ _ _

H) Policy number / Name of corporate: _ I) Employee ID: _

J) Currently do you have any other Mediclaim / Health insurance: Yes: _ _ _ _ No: _ _ _ _ Company Name: _

Give details: _

K) Do you have a family physician: Yes: _ _ _ _ No: _ _ _ _ l) Name of the family physician: _

M) Contact number, if any: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)**

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

A) Name of the treating doctor: _ B) Contact Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

C) Nature of ILLNESS / Disease with presenting complaints: _

_ _

_ _

D) Relevant clinical findings: _

_ _

_ _

E) Duration of the present ailment: _ _ _ _ _ _ _ _ _ _ Days i) Date of first consultation: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Ii) Past history of present ailment if any: _

_ _

_ _

F) Provisional diagnosis: _

_ _

I) ICD 10 Code: _

G) Proposed line of treatment: Medical Management: _ _ _ _ _ _ _ _ _ _ Surgical Management _ _ _ _ _ _ _ _ _ _ Intensive care: _ _ _ _ _ _ _ _ _ _

Investigation: _ _ _ _ _ _ _ _ _ _ Non allopathic treatment: _ _ _ _ _ _ _ _ _ _

H) If Investigation & / or Medical Management provide details: _

_ _

i) Route of drug administration: _

_ _

I) If Surgical, name of surgery: _

_ _

ZURICH kotak
General Insurance

I) ICD 10 PCS Code: _____

J) If other treatments provide details: _____

_____

K) How did injury occur: _____

_____

L) In case of accident: I) is it RTA: Yes____ No____ ii) Date of injury: _____ iii) Reported to Police: Yes____ No____

iv) FIR No: _____ v) In case of Maternity: G ____ P____ L ____ A ____ Date of Delivery: ____ _____

Details of the patient admitted

A) Date of admission: ____ _____ B) Time: _____

C) Is this an emergency / a planned hospitalization event? : Emergency / Planned

D) Expected no. of days stay in hospital: Days_____ E) Room Type_____

F) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs: _____

G) Expected cost for investigation + diagnostics. : Rs: _____

H) ICU Charges: Rs: _____

I) OT Charges: Rs: _____

J) Professional fees Surgeon + Anesthetist Fees + consultation Charges: Rs: _____

K) Medicines + Consumables + Cost of Implants Other Hospital expenses if any: Rs: _____

L) All-inclusive package charges if any applicable Rs: _____

M) **Sum Total expected cost of hospitalization** Rs: _____

Mandatory: Past History of any chronic illness	**if yes, since (month / year)**
Diabetes _____	____ _____
Heart Disease	____ _____
Hypertension	____ _____
Hyperlipidemias	____ _____
Osteoarthritis	____ _____
Asthma / COPD / Bronchitis	____ _____
Cancer	____ _____
Alcohol or drug abuse	____ _____
Any HIV or STD / Related aliments	____ _____

Any other Ailment give details: _____

_____

_____

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

A) Name of the treating doctor: _____

B) Qualification: _____ C) Registration No. with State Code: _____

Hospital Seal (Must include Hospital ID): _____ Patient / Insured Name & Signature: _____

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General Insurance

PAGE 2: NOT TO BE
FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

A) **Patient's / Insured's Name:** ____

B) **Contact number:** ______________________________

C) **Patient's / Insured's Signature:** ____________________

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorization form will be collected from the patient.
4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal: ________________________ **Doctor's Signature:** ____________________

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.