

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 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.			

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

(To be filled in block letter)

DETAILS OF PRIMARY INSURED

a) Policy No :

b) Sl. No/certificate No :

c) Company ID No :

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City : State :

Pin Code : Phone No : Email ID :

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 yy (copy of policies to be attached)

c) If Company Name : Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year? Yes No Date : dd mm yy Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : Yes No f) If Yes, Company Name :

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name : SURNAME FIRST NAME MIDDLE NAME

b) Gender : Male Female c) Age : Year yy Months mm d) Date of Birth dd yy mm

e) Relationship to Primary Insured : Self Spouse Child Father Mother Other (Please specify)

f) Occupation : Service Self Employed Homemaker Student Retired Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

DETAIL 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 Disease First Detected / Date of Delivery : dd yy mm

e) Date of Admission : dd yy mm f) Time : hh mm g) Date Of Discharge : dd yy mm h) Time : hh mm

i) If Injury Give Cause : Self Inflicted Road Traffic Accident Substance / 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 :

DETAIL OF CLAIM

a) Details of The Treatment Expenses Claimed

i. Pre-hospitalization Expenses : Rs.	<input type="text"/>	ii. Hospitalization Expenses : Rs.	<input type="text"/>
iii. Post-hospitalization Expenses : Rs.	<input type="text"/>	iv. Health-Check up Cost : Rs.	<input type="text"/>
v. Ambulance charges : Rs.	<input type="text"/>	vi. Other (code) : <input type="text"/>	Rs. <input type="text"/>
vii. Pre-hospitalisation period : days	<input type="text"/>	Total Rs.	<input type="text"/>
		viii. Post-hospitalization Period : days	<input type="text"/> dd <input type="text"/> yy <input type="text"/> mm

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 : Rs.	<input type="text"/>	ii. Surgical Cash : Rs.	<input type="text"/>
ii. Critical Illness Benefit : Rs.	<input type="text"/>	iv. Convalescence : Rs.	<input type="text"/>
v. Pre/Post Hospitalization Lump Sum Benefit : Rs.	<input type="text"/>	vi. Other : Rs.	<input type="text"/>
		Total Rs.	<input type="text"/>

(IMPORTANT : PLEASE TURN OVER)

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

Claim Documents Submitted - Check List

- | | |
|--|---|
| <input type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Operation Theater Notes |
| <input type="checkbox"/> Copy of the claim Intimation | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital Main Bill | <input type="checkbox"/> Doctor's Request For Investigation |
| <input type="checkbox"/> Hospital Break-up Bill | <input type="checkbox"/> Investigation Report (Including CT / MRI/ USG / HPE) |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospital Discharge Summary | |
| <input type="checkbox"/> Pharmacy Bill | |

DETAILS OF BILL ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs.)
1.		d d m m y y		Hospital Main Bill	
2.		d d m m y y		Pre-hospitalization: _____ Nos	
3.		d d m m y y		Pre-hospitalization: _____ Nos	
4.		d d m m y y		Pharmacy Bills	
5.		d d m m y y			
6.		d d m m y y			
7.		d d m m y y			
8.		d d m m y y			
9.		d d m m y y			
10.		d d m m y y			

DETAILS PRIMARY INSURED'S ACCOUNT

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, my right to claim reimbursement shall be forfeited. I also consent & authorize 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 :

 Place :

Signature of the insured

Claim Form - Part B

(To be filled in block letter)

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

DETAILS OF HOSPITAL

a) Name of Hospital :

b) Hospital ID : c) Type of Hospital : Network Non Network (If non network section E)

d) Name of the treating doctor : *S U R N A M E F I R S T N A M E M I D D L E N A M E*

e) Qualification : f) Registration No. with State Code :

g) Phone No :

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient : *S U R N A M E F I R S T N A M E M I D D L E N A M E*

b) IP Registration Number : c) Gender : Male Female d) Age : Year Months

e) Date of Birth : f) Date of Admission : g) Time :

h) Date of Discharge : i) Time : j) Type of Admission : Emergency Planned Day Care Maternity

k) If Maternity : i. Date of Delivery : ii. Grade of status :

j) Status at time of discharge : Discharge to home Discharge to another hospital Deceased

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	Description
i) Primary Diagnosis :	<input type="text"/>	<input type="text"/>	i) Procedure 1 :	<input type="text"/>	<input type="text"/>
ii) Additional Diagnosis :	<input type="text"/>	<input type="text"/>	ii) Procedure 2 :	<input type="text"/>	<input type="text"/>
iii) Co-morbidities :	<input type="text"/>	<input type="text"/>	iii) Procedure 3 :	<input type="text"/>	<input type="text"/>
iv) Co-morbidities :	<input type="text"/>	<input type="text"/>	iv) Details of Procedure :	<input type="text"/>	<input type="text"/>

c) Present ailment is a complication of PED? Yes No i) (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

i) If injury due to substance abuse/ alcohol consumption, Test Conducted to establish this : Yes No (If Yes, Attach Report) iii) If Medico Legal : Yes No

v) FIR no : vi) If not reported to police give reason: _____

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

<input type="checkbox"/> Claim Form Duly Singed	<input type="checkbox"/> Investigation report
<input type="checkbox"/> Original Pre-authorization request	<input type="checkbox"/> CT/MR/USG/HPE investigation report
<input type="checkbox"/> Copy of Pre-authorization Approval latter	<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 Theater notes	<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Hospital main bill	<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Hospital break-up bill	<input type="checkbox"/> Any other, please specify

(IMPORTANT : PLEASE TURN OVER)

SECTION A

SECTION B

SECTION C

SECTION D

DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of Hospital :

City : State :

Pin Code : b) Phone No : c) Registration No :

d) PAN e) Number of Inpatient beds : f) Facilities available in the hospital : i) OT : Yes No ii) ICU : Yes No

iii) Other :

DECLARATION BY THE INSURED

(PLEASE READ VERY CAREFULLY)

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 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 : Place : Signature of the insured

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 my 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.

Date : Place : 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