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.

HEALTH INSURANCE

Health Assurance Claim Form

(For official use only)

Claim No. | | | | | | | Date: D D M M Y Y Y Y

Please provide the following information fully to enable us to process your claim appropriately.No.

1. Policy number (In full) / Customer Id | | | | | | |

2. Details of the Insured Person

a) Name of the patient:

b) Relationship with the Proposer: ☐ Self ☐ Spouse ☐ Son ☐ Daughter

c) Current address:

City State

Date of admission D D M M Y Y Y Y Time of admission

Date of discharge D D M M Y Y Y Y Time of discharge

3. Cover being claimed for:

a). CritiCare

1. Cancer of Specified Severity ☐	2. First Heart Attack of Specified Severity ☐
3. Open Chest CABG ☐	4. Open Heart Replacement or Repair of Heart Valves ☐
5. Coma of Specified Severity ☐	6. Kidney Failure Requiring Regular Dialysis ☐
7. Stroke Resulting in Permanent Symptoms ☐	8. Major Organ/BoneMarrow Transplant ☐
9. Permanent Paralysis of Limbs ☐	10. Motor Neurone Disease with Permanent Symptoms ☐
11. Multiple Sclerosis with Persisting Symptoms ☐	12. Major Burns ☐
13. Fulminant Viral Hepatitis ☐	14. End-stage Lung Disease ☐
15. Aplastic Anemia ☐	16. Loss of Speech ☐
17. Deafness ☐	18. End Stage Liver Disease ☐
19. Muscular Dystrophy ☐	20. Bacterial Meningitis ☐

b). HospiCash ☐

c). AccidentCare

i. Accident Death ☐	ii. Accident Permanent Total Disability ☐
iii. Accident Permanent Partial Disability ☐	iv. Temporary Total Disability ☐
v. Accident Hospitalization ☐	

4.Date on which injury was sustained /disease or illness first detected D D M M Y Y Y Y

HEALTH INSURANCE

5. Details of the attending doctor

Name of the doctor

Address of the doctor

City Pin code

Qualification Phone

Registration No.

6. Details of the hospital

Hospital Name

Address of the hospital

City Pin code

State Phone

Registration No.

7. Date of admission D D M M Y Y Y Y

8. Details of claim

	Expense Head	Amount
1.	CritiCare	
2.	HospiCash	
3.	AccidentCare	
	3a. Accident Death	
	3b. Accident Permanent Total Disability	
	3c. Accident Permanent Partial Disability	
	3d. Children's Education Allowance	
	3e. Funeral Expenses	
	3f. Accident Temporary Total Disability	
	3g. Accident Hospitalization	
	Total Claimed Amount (A)	

If you have opted for CritiCare option 2, no seperate claim form would be required.
The amount due shall get credited into the account automatically.

9. Number of document(s) submitted including this claim form

10. Please enclose the following documents:

A. Accident Death

a) Duly filled and signed claim form and KYC documents
b) Copy of Death Certificate (issued by the office of Registrar of Births and Deaths)
c) Copy of First Information Report (FIR) / Panchnama
d) Copy of Medico Legal Certificate duly attested by the concerned hospital, if applicable
e) Copy of Hospital Record, if applicable
f) Copy of Post Mortem Report wherever applicable

B. Accident Permanent Total Disability

a) Duly filled and signed claim form and KYC documents
b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
c) Final Hospital Bill (in original)/self attested copies if the originals are submitted with another insurer
d) Medical consultations and investigations done from outside the hospital
e) Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government
f) Copy of First Information Report (FIR)/Panchnama if applicable
g) Copy of Medico Legal Certificate duly attested by the concerned hospital, if applicable

C. Accident Permanent Partial Disability

a) Duly filled and signed claim form and KYC documents
b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
c) Final Hospital Bill (in original)/self attested copies if the originals are submitted with another insurer
d) Medical consultations and investigations done from outside the hospital
e) Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government
f) Copy of First Information Report (FIR)/Panchnama if applicable
g) Copy of Medico Legal Certificate duly attested by the concerned hospital, if applicable

D. Accident Temporary Total Disability

a) Duly filled and signed claim form and KYC documents
b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
c) Final Hospital bill (in original)/self attested copies if the originals are submitted with another insurer
d) Copy of First Information Report (FIR)/Panchnama/Inquest report if applicable
e) Copy of Medico Legal Certificate duly attested by the concerned hospital if applicable
f) Attendance record of employer/Certificate of employer confirming period of absence
g) Disability certificate from treating doctor with seal and stamp
h) Medical certificate and Fitness certificate with seal and stamp

E. Accident Hospitalization

a) Duly filled and signed claim form and KYC documents
b) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer
c) Copy of First Information Report (FIR)/Panchnama/Inquest report if applicable
d) Copy of Medico Legal Certificate duly attested by the concerned hospital if applicable
e) Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them
f) Original bills with supporting prescriptions and reports for investigations done outside the hospital/copies attested by other insurer if the originals are submitted with them
g) Original bills with supporting prescriptions for medicines purchased from outside the hospital/copies attested by other insurer if the originals are submitted with them

F. CritiCare

a) Duly filled and signed claim form and KYC documents
b) Final Hospital Discharge Summary in original/self attested copies if the originals are submitted with another insurer, if applicable
c) Final Hospital Bill in original/self attested copies if the originals are submitted with another insurer, if applicable
d) Consultation notes and/or investigation reports from outside the hospital prior to hospitalization
e) First consultation note and all medical record since onset of complaint
f) Copy of First Information Report (FIR) (if CritiCare being claimed for is admissible in event of an Accident)
g) Copy of Medico Legal Certificate duly attested by the concerned hospital (if CritiCare being claimed for is admissible in event of an Accident) if applicable

G. HospiCash

a) Duly filled and signed claim form with KYC documents
b) Final Hospital Discharge Summary in original/self attested copies if the originals are submitted with another insurer
c) Final Hospital Bill in original/self attested copies if the originals are submitted with another insurer
d) Consultation notes and/or investigation reports from outside the hospital prior to hospitalization
e) Copy of First Information Report (FIR)/Panchnama (In case of accidental injury) if applicable
f) Copy of Medico Legal Certificate (In case of accidental injury) if applicable

Note: 1. We may ask for additional documents if required for claim processing
2. No documents are to be provided for claiming Funeral Expenses and Children Education Expenses

HEALTH INSURANCE

11. Is Insured Person at present covered under any type of Health Insurance (Individual or Group) ☐ Yes ☐ No

If yes, please give the details as follows:

Name of Insurance Company	Policy No.	Application No.	Insured From (Date)	To (Date)	Sum Insured

12. Is Insured Person at present covered under any Personal Accident cover (Individual or Group) ☐ Yes ☐ No

If yes, please give the details as follows:

Name of Insurance Company	Policy No.	Application No.	Insured From (Date)	To (Date)	Sum Assured

The submission/receipt of this form does not amount to admission of any liability under the claim on the part of the insurers. I here by authorize Max Bupa Health Insurance Company Limited to transfer the claim amount payable under this claim to the following bank account.

Account holder's name Bank

Account No. Branch City

IFSC code MICR code

☐ Please tick if you want the payment to be made via cheque. The cheque will be sent to the policy holder's address.

Please refer to the Max Bupa policy guide for detailed information of the benefits that Insured Person is eligible under the policy.

Note:

MICR Code: The MICR code can be found on the bottom of the cheque/cheque book. It appears after the cheque number
IFSC Code: The IFSC code is listed on your cheque/cheque book. In case it is not listed, please request your bank for the same

Declaration:

I hereby declare and warrant that the information given above and the information that will be given in respect of this claim is correct and complete. I further agree and understand that if any false statement or declaration is made or used with repect to such claim or if any fraudulent act, means or devices are used to obtain benefit under this Policy then this policy shall be void and all claims being processed shall be forfeited for any/all Insured Persons and all sums paid under this policy shall be repaid to Us by the beneficiary under the Policy I further authorize any hospital, physician Insurance Company or Organization that has any records or knowledge of me or my health to furnish such information to Max Bupa Health Insurance Company Limited ("Max Bupa") and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that if I and/or the member(s) fail to provide any information requested in this claim form, it may result in the inability of Max Bupa to accept or process this claim.

I understand that all Customer personal Information collected or held by Max Bupa will be used for processing the claims and analysis related to Insurance / Reinsurance business.

Date D D M M Y Y Y Y

Name and Signature of Claimant

Annexure 1: Consent Letter

To,
Medical Superintendent,

_____

_____

Date: / /

I, Mr./Ms. _____ Age _____ resident of _____ State _____ hereby give my willful consent to Mr/Dr _____of Max Bupa Health Insurance Company Limited to verify and collect necessary documents/statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my insurance claim.

My other relevant details are provided below;

Detail of Insured: _____

DOA: _____

DOD: _____

MRD/Indoor/IP No: _____

Policy No: _____

I request you to provide all the information/documents as required by Max Bupa Health Insurance Company Ltd.

Name:

_____ _____

Signature/ Thumb Impression **Witness Name & Signature**