

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 B

(To be filled in BLOCK LETTERS)

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

SECTION A - DETAILS OF HOSPITAL

Form fields for Section A: a) Name of the Hospital, b) Hospital ID, c) Type of Hospital (Network/Non Network), d) Name of the treating doctor, e) Qualification, f) Registration No with state code, g) Phone No, l) Email Id.

SECTION B - DETAILS OF PATIENT ADMITTED

Form fields for Section B: a) Name of the patient, b) IP Registration Number, c) Gender (Male/Female), e) Age (years/months), d) Date of birth, e) 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) Gravida Status, l) Status at time of discharge (Discharge to home/Discharge to another hospital/Deceased), m) Total claimed amount.

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part A

Table with 3 columns: S.No, ICD 10 Codes, Description. Rows include Primary Diagnosis, Additional Diagnosis, and Co-morbidities.

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part B

Table with 3 columns: S.No, ICD 10 PCS, Description. Rows include Procedure 1, Procedure 2, Procedure 3, and Details of procedure.

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- c) Pre - authorization obtained Yes No
- d) Pre - authorization number _____
- e) If authorization by network hospital not obtained, give reason _____
- f) 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 _____

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

S.No	Documents	S.No	Documents
1	<input type="checkbox"/> Claim form duly signed	9	<input type="checkbox"/> Investigation reports
2	<input type="checkbox"/> Original pre authorization request	10	<input type="checkbox"/> CT/MRI/USG/HPE investigation reports
3	<input type="checkbox"/> Copy of pre - authorization approval letter	11	<input type="checkbox"/> Doctor's reference slip for investigation
4	<input type="checkbox"/> Copy of photo ID card of patient verified by hospital	12	<input type="checkbox"/> ECG
5	<input type="checkbox"/> Hospital discharge summary	13	<input type="checkbox"/> Pharmacy bills
6	<input type="checkbox"/> Operation theatre notes	14	<input type="checkbox"/> MLC report & police FIR
7	<input type="checkbox"/> Hospital main bill	15	<input type="checkbox"/> Original death summary from hospital where applicable
8	<input type="checkbox"/> Hospital break up bill	16	<input type="checkbox"/> Any other, please specify

SECTION E - 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 with state code _____
- d) Hospital PAN _____ e) Number of Inpatients bed _____
- f) Facilities available in the hospital i) OT Yes No ii) ICU Yes No iii) Others _____

SECTION F - DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in the claim form is true & correct to the best of 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.

Date | d | d | m | m | y | y | y | y | Place _____ Signature & Seal of 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