Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006

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 letters)

DETAILS OF PRIMARY INSURED:

a) Policy No:

b) Sl. No/ Certificate No: c) Phs No./ TPA ID No:

d) Name :

e) Address :

City: State:

Phone No: Pin Code:

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: D D M M Y Y (Copies of Policies to be attached)

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? ☐ Yes ☐ No

Date: M M Y Y Diagnosis:

e) Previously covered by any other Mediclaim / Health insurance : ☐ 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:s D D M M Y Y

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

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

g) Address (if different from above):

City: State:

Pin Code: Phone 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 I Date Disease first detected IDate of Delivery: D D M M Y Y

e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M Y Y

h) Time: H H : M M

i) If Injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse I 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:

DETAILS OF CLAIM:

a] Details of the treatment expenses claimed

Sr no.	Expense	Rs.
i	Pre-hospitalization Expenses	
ii	Hospitalization Expenses	
iii	Post-hospitalization Expenses	
iv	Health-Check up Cost	
v	Ambulance Charges	
vi	Others (code)	
	Total	
vii	Pre-hospitalization period: Days	
viii	Post-hospitalization period: Days	

b] Details of Lump sum I cash benefit claimed

Sr no.	Expense	Rs.
i	Hospital Daily Cash	
ii	Surgical Cash	
iii	Critical Illness Benefit	
iv	Convalescence	
v	PreIPost hospitalization Lump sum benefit	
vi	Others (code)	
	Total	

Claim Documents Submitted Check List

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT I MRI I USG I HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

c] Claim for Domiciliary Hospitalization ☐ Yes ☐ No (If Yes, provide details in annexure)

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Pre-hospitalization Bills: Nos	
2		D D M M Y Y		Hospital Main Bill	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Health-Check Up Cost	
5		D D M M Y Y		Ambulance Charges	
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			
				Total	

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) IFSC Code:

d) Bank Name: e) Branch:

f) Cheque / DD Payable details:

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 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.

Date: D D M M Y Y Place: Signature of the Insured

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 Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

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) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y

f) Date of Admission: D D M M Y Y g) Time: H H : M M h) Date of Discharge: D D M M Y Y g) Time: H H : M M

j) Type of Admission: Emergency Maternity ☐ Planned ☐ Day Care ☐ k) If Maternity i. Date of Delivery: D D M M Y Y ii. Gravida Status:

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

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description
i Primary Diagnosis:		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
v. Co-morbidities:		

b)	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

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 v. Reported to Police: ☐ Yes ☐ No

v. FIR no (If Yes, specify details)

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

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

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.:

d) Hospital 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 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 TPA I insurance company, to seek necessary medical information I documents from any hospital I Medical Practitioner who has attended on the person against whom this claim is made.I hereby declare that I have included all the bills I receipts for the purpose of this claim & that I will not be making any supplementary claim except the prelpost hospitalization claim, if any.

Date: D D M M Y Y 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 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

Signature and Seal of the Hospital Authority

Date: D D M M Y Y Place: