

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 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)		
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 <input checked="" type="checkbox"/> or <input type="checkbox"/> 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
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED
CIN: U74899DL2000PLC107621
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)

A. 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. _____

B. DETAILS OF THE PATIENT ADMITTED:

a) Name of the Patient: _____
b) IP Registration Number: _____ c) Gender: Male Female d) Age: Years _____ 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: _____ Gravidity Statu _____
l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total Claimed Amount: Rs. _____

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) ICD 10 Codes _____ Description _____
i. Primary Diagnosis: _____
ii. Additional Diagnosis: _____
iii. Co-morbidities: _____
iv. Co-morbidities: _____
b) ICD 10 Codes _____ Description _____
i. Procedure 1: _____
ii. Procedure 2: _____
iii. Procedure 3: _____
iv. Details of Procedure: _____
c) Present ailment is a complication of PED? Yes No (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
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: _____

D. CLAIM DOCUMENTS SUBMITTED - CHECK LIST

<input type="checkbox"/> Claim Form duly signed	<input type="checkbox"/> Operation Theatre notes	<input type="checkbox"/> Doctor's reference slip for investigation
<input type="checkbox"/> Original Pre-authorization request	<input type="checkbox"/> Hospital main bill	<input type="checkbox"/> ECG
<input type="checkbox"/> Copy of the Pre-authorization approval letter	<input type="checkbox"/> Hospital break-up bill	<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> Copy of photo ID card of patient verified by hospital	<input type="checkbox"/> Investigation reports	<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Hospital Discharge summary	<input type="checkbox"/> CT/MR/USG/HPE investigation reports	<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Any other, please specify _____		

E. ADDITIONAL 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.: _____ Date of Registration: _____
Expiry date of Registration: _____ Name of the Registering Authority: _____
d) PAN: _____ e) Number of Inpatient beds _____ f) Facilities available in the hospital: i. OT: Yes No ii. ICU: Yes No
iii. Others: _____

F. 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.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below-

- o Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- o Has fully qualified nursing staff under its employment round the clock
- o Has fully qualified doctor(s) in charge round the clock
- o Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- o Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Date: _____

Place: _____

Signature of Insured / Claimant: _____

Signature and Seal of the Hospital Authority: _____