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 : Name of Corporate:		Phone (STD) :							
	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	Remarks						
51110		Status(Y/N)	Kemarko						
	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) Original Final Hospital bill with cost wise breakup of each Item								
9 10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)								
10	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip								
10.a	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								
	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	V 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.									

Annexure - III

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY											
DETAILS OF THE THIRD PART	TY ADMINISTRATOR						(To be filled in block	k letters)			
 a) Name of TPA / Insurance corb) Toll free phone number: c) Toll free FAX: 	npany:										
			TO BE FILLED BY THE IN	ISURED / PATIENT							
 a) Name of the Patient: b) Gender: e) Insured card ID number: g) Employee ID: i. Company Name iii. Policy No. i) Name of the family physician: 			image: square image: square<	Policy number / Corpc ediclaim / Health insur ii. G	arce: Yes ive details: iv. Sum Insure iv. Sum Insure ive COMPLET						
			FILLED BT THE TREAT	NO DOCTOR / HOSP							
 a) Name of the treating doctor: c) Nature of ILLNESS / Disease with presenting complaints e) Duration of the present ailment: f) Provisional diagnosis: 	Days I) Da	te of first consultation		of priailme							
g) Proposed line of treatment :	Medical Management	Surgical Man	agement Intensi	,] Investigation	Non allopathic treatmer	at				
 h) If Investigation & / or Medical Management provide details 				i) Route of drug adm							
i) If Surgical, name of surgery :				I) ICD 10 P	CS Code:						
j) If other treatments provide details:				k) How did ir	njury occur:						
I) In case of accident: II) Is it RT	A: Yes No III) Date	e of injury: DD	M M Y Y	iv) Reported to Pol	ice: 🗌 Yes 📃 I	No FIR No					
V) Injury / Disease caused due	to substance abuse / alcohol c	onsumption: Yes	No VI) Test con	ducted to establish this	s: Yes I	No (If Yes, attach reports)					
I) In case of Maternity:	□ G □ P [L A		LMP	D M M	ΥΥ					
Details of the patient admitted				Ма	ndatory: Past His	tory of any chronic illness	If yes, since (mon	th / year)			
a) Date of admission:	D D M M	Y Y b)	Time: H H : M	Μ	Diabetes		M	ΥΥ			
c) Is this an emergency / a plann	ed hospitalization event?:	Emergency	Planned		Heart Disea	ase	M	ΥΥ			
d) Expected no. of days stay in hospital: Days e) Room Type:					Hypertensio	on	M	ΥΥ			
f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.				Hyperlipide	mias	M	ΥY				
g) Expected cost for investigation	n + diagnostics. :	Rs.			Osteoarthri	tis	M	ΥY			
h) ICU Charges:		Rs.			Asthma / C	OPD / Bronchitis	M	ΥΥ			
i) OT Charges:		Rs.			Cancer		M	ΥY			
j) Professional fees Surgeon + A	nesthetist Fees + consultation	Charges: Rs.			Alcohol or o	drug abuse	M	ΥΥ			
 k) Medicines + Consumables + C specify) . Other hospital exper 		lease Rs.				STD / Related ailments	M	ΥΥ			
I) All inclusive package charges if any applicable Rs.											
m) Sum Total expected cost of	hospitalization	Rs.									
						(PLE	ASE READ VERY CARE	EFULLY)			
			DECLARAT	ION							
We confirm having read understo											
a) Name of the treating doctor: b) Qualification:		C) Registration No. wit	F I R S T][']["]["]["]["]["]["]["]["]["]["]["]["]["]					
Signature of treating doctor		Hospital	Seal (Must include Hospit	al ID)		Patient / Insured Name & Sig	gnature:				

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE PATIENT / REPRESENTATIVE

- 1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- 2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- 3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form
- 4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
- 5.1 agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- 6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance

7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name:

b) Contact number:

d) Patient's / Insured's Signature:

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

- 2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
- 3. All non medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
- 4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
- 5. The patient declaration has been signed by the patient or by his representative in our presence.
- 6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- 7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature



DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital

- 2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
- 3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
- 4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
- 5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.