

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 FOR HEALTH INSURANCE POLICIES

OTHER THAN TRAVEL AND PERSONAL ACCIDENT

The issue of this form is not to be taken as an admission of liability.

(Guidance for filling claim form - Part A is available on our website: www.royalsundaram.in)

PART A

DETAILS OF PRIMARY INSURED (PROPOSER)

(TO BE FILLED IN BY THE INSURED)

MOST IMPORTANT	a) Policy No.											b) Sl. No./ Certificate No.										
	c) Membership No./ TPA ID No.																					
	d) Name																					
	e) Address																					
	City											State										
	Pin Code											Land Line (with STD Code)										
	PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.																					
	Mobile No.											Email ID										
	Alternate Email ID																					

SECTION A

DETAILS OF INSURANCE HISTORY (MANDATORY)

a) Currently covered by any other Mediclaim/Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
b) If yes, Company Name																								
Policy No.											c) Date of commencement of first Insurance without break													
d) Sum Insured (Rs.)											e) Have you been hospitalized in the last four years since inception of the contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No		f) Date										
g) Diagnosis																								

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name																					
b) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		c) Age	Y Y Years		M M Months		d) Date of Birth													
e) Relationship to Primary insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		<input type="checkbox"/> Father		<input type="checkbox"/> Mother		<input type="checkbox"/> Other (Please Specify) _____														
f) Communication Address																					
City											State										
Pin Code											Land Line (with STD Code)										
g) Occupation	<input type="checkbox"/> Doctor <input type="checkbox"/> Service <input type="checkbox"/> Self Employed		<input type="checkbox"/> Homemaker		<input type="checkbox"/> Student		<input type="checkbox"/> Retired <input type="checkbox"/> Other (Please Specify) _____														
h) Name of the Employer																					
i) Address of the Employer																					

SECTION C

DETAILS OF HOSPITALIZATION

a) Name & Address of Hospital where Admitted																					
City											State										
Pin Code											Land Mark										
b) Room Category occupied	<input type="checkbox"/> Day care <input type="checkbox"/> Single occupancy		<input type="checkbox"/> 3 or more beds per room		<input type="checkbox"/> Any other category, Pls specify _____																
c) Hospitalization due to	<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity		d) Date of Injury/Date Disease first detected																		
e) Date of Admission					Time			f) Date of Discharge					Time								
g) In case of maternity,	1 Date of Delivery						2 Gravida Status _____														
h) If Injury, give cause	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road Traffic Accident		<input type="checkbox"/> Substance Abuse/Alcohol Consumption																		
1. If Medico legal		<input type="checkbox"/> Yes <input type="checkbox"/> No		2. Reported to police		<input type="checkbox"/> Yes <input type="checkbox"/> No		3. MLC Report & Police FIR attached		<input type="checkbox"/> Yes <input type="checkbox"/> No											
i) System of Medicine																					

SECTION D

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	<input type="text"/>	2. Hospitalization Expenses	Rs.	<input type="text"/>
3. Post-hospitalization Expenses	Rs.	<input type="text"/>	4. Health-Check up Cost	Rs.	<input type="text"/>
5. Ambulance Charges	Rs.	<input type="text"/>	6. Others	Rs.	<input type="text"/>
			Total amount claimed	Rs.	<input type="text"/>

b) Claim for Domiciliary Hospitalization Yes No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash	Rs.	<input type="text"/>	2. Surgical Cash	Rs.	<input type="text"/>
3. Critical Illness Benefit	Rs.	<input type="text"/>	4. Convalescence	Rs.	<input type="text"/>
5. Pre/Post hospitalization Lump sum benefit:	Rs.	<input type="text"/>	6. Others_____	Rs.	<input type="text"/>
No of days (Pre Hospitalisation)_____			Total amount claimed	Rs.	<input type="text"/>
No of days (Post Hospitalisation)_____					

Check List of Claim Documents to be submitted (In original)* - Please tick relevant box (For Hospital Cash benefit, photocopies of claim documents are acceptable)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Claim Form Duly signed | <input type="checkbox"/> Copy of the claim intimation, if any | <input type="checkbox"/> Hospital Main Bill | <input type="checkbox"/> Hospital Break-up Bill |
| <input type="checkbox"/> Advance and final bill payment receipt (Mandatory) | <input type="checkbox"/> Pharmacy Bill | <input type="checkbox"/> Hospital Discharge Summary | <input type="checkbox"/> Investigation Reports (Including CT/MRI/USG/HPE/ECG) |
| <input type="checkbox"/> Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital | <input type="checkbox"/> Doctor's request for investigation | <input type="checkbox"/> Test report and prescription relating to first consultation for the illness | <input type="checkbox"/> FIR/MLC in case of accident injury and English translation of the same if it is in any other language |
| <input type="checkbox"/> KYC document (Address proof, ID proof only for claims exceeding Rs. 1 Lakh) | <input type="checkbox"/> Cancelled Cheque leaf of the bank account held in the name of the primary insured (Mandatory) | <input type="checkbox"/> Operation Theatre Notes | |
| <input type="checkbox"/> Original Death Summary (Wherever applicable) | | | |

***Please retain copy of complete set of claim documents for your records**

DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y Y Y		Hospital Main Bill	
2		D D M M Y Y Y Y		Pre-hospitalization Bills: (Nos____)	
3		D D M M Y Y Y Y		Post-hospitalization Bills: (Nos____)	
4		D D M M Y Y Y Y		Pharmacy Bills: (Nos____)	
5		D D M M Y Y Y Y			

Hospital Main Bill Payment Receipts only

Receipt No	Date	Amount	Please Tick Relevant Box
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt

Note : Please attach separate sheet if necessary

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN b) Account Number

c) Bank Name and Branch

d) IFSC Code

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 with respect to questions asked in relation to this claim, 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 Place Signature of the Primary Insured

Royal Sundaram General Insurance Co. Limited
 (Formerly known as Royal Sundaram Alliance Insurance Company Limited)
 Corporate Office: Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.
 IRDAI Registration No.102 | CIN: U67200TN2000PLC045611

SECTION E

SECTION F

SECTION G

SECTION H

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

(Guidance for filling claim form- Part B is available on our website: www.royalsundaram.in)



Royal Sundaram

General Insurance

DETAILS OF HOSPITAL

a) Name of the hospital	<input type="text"/>
b) Hospital ID	<input type="text"/>
(For Office use only)	
c) Type of Hospital	<input type="checkbox"/> Network <input type="checkbox"/> Non Network (If non network fill section D)
d) Name of the treating Doctor	<input type="text"/>
e) Qualification	<input type="text"/>
f) Registration No. with State Code	<input type="text"/>
g) Phone	<input type="text"/>

SECTION A

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:	<input type="text"/>											
b) IP Registration Number	<input type="text"/>											
c) Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	d) Age	<input type="text"/> Y <input type="text"/> Y	Years	<input type="text"/> M <input type="text"/> M	Months	e) Date of Birth	<input type="text"/> D <input type="text"/> D	<input type="text"/> M <input type="text"/> M	<input type="text"/> Y <input type="text"/> Y	<input type="text"/> Y <input type="text"/> Y
f) Type of Admission	<input type="checkbox"/> Emergency	<input type="checkbox"/> Planned	<input type="checkbox"/> Day Care	<input type="checkbox"/> Maternity								
g) Date of Admission	<input type="text"/> D	<input type="text"/> D	<input type="text"/> M	<input type="text"/> M	<input type="text"/> Y	<input type="text"/> Y	<input type="text"/> Y	<input type="text"/> Y	Time	<input type="text"/> H	<input type="text"/> H	: <input type="text"/> M <input type="text"/> M
h) Date of Discharge	<input type="text"/> D	<input type="text"/> D	<input type="text"/> M	<input type="text"/> M	<input type="text"/> Y	<input type="text"/> Y	<input type="text"/> Y	<input type="text"/> Y	Time	<input type="text"/> H	<input type="text"/> H	: <input type="text"/> M <input type="text"/> M
i) If Maternity												
1. Date of Delivery	<input type="text"/> D	<input type="text"/> D	<input type="text"/> M	<input type="text"/> M	<input type="text"/> Y	<input type="text"/> Y	<input type="text"/> Y	<input type="text"/> Y	2. Gravida Status	_____		
j) Status at time of discharge	<input type="checkbox"/> Discharge to home	<input type="checkbox"/> Discharge to another hospital	<input type="checkbox"/> Deceased									

SECTION B

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis	<input type="text"/>	_____	<input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y
2. Additional Diagnosis	<input type="text"/>	_____	<input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y
3. Co-morbidities	<input type="text"/>	_____	<input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y
4. Co-morbidities	<input type="text"/>	_____	<input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y
ICD 10 PCS Codes			
1. Procedure(1)	<input type="text"/>	_____	
2. Procedure(2)	<input type="text"/>	_____	
3. Procedure(3)	<input type="text"/>	_____	
4. Details of any other Procedure	<input type="text"/>	_____	

SECTION C

a) Whether preauthorisation obtained Yes No. If yes, Preauthorisation No. _____

b) If Authorisation by network hospital not obtained, please give reason _____

c) Hospitalization due to Injury Yes No If Yes, give cause _____

1. Self-inflicted Road Traffic Accident Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: Yes No

If Yes, details of tests conducted _____

3. If Medico legal Yes No 4. Reported to Police Yes No 5. FIR No.

6. If not reported to police, give reason _____

d) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation)

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

e) Please give previous medical history of the patient

f) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

	Say Yes/No	Duration in Year	Duration in Month
1. Bronchial Asthma			
2. Chronic Obstructive Pulmonary disease			
3. Hypertension			
4. Diabetes			
5. Heart ailment			
6. Arthritis of any kind			
7. Cerebro vascular attack			
8. Seizure disorder			
9. Renal/Kidney Disorder			
10. Congenital conditions			
11. Developmental anomalies			
12. Any other			

g) Is the ailment a complication / sequel of a pre-existing disease or condition?

If Yes , please give details

h) History of alcoholism Yes No
If yes : No of years _____
Quantity consumed per day _____

i) History of Smoking/ Tobacco chewing Yes No
If yes : No of years _____
Units consumed per day _____

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City

 State

d) Hospital PAN

 e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT Yes No 2. ICU Yes No 3. Round the clock Doctor/Nurses Yes No
4. Maintains daily record of patients Yes No
5. Others _____

SECTION D

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, insured's right to claim under this policy shall be forfeited.

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Place

 Signature and Seal of the Hospital Authority

SECTION E



Authorization Letter (Mandatory)

Date:

From:

To:

The Manager/ Medical Superintendent,
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:_____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____ (Third admission) in _____Hospital

I consent and authorize M/s Royal Sundaram General Insurance Co. Limited and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and/or meet/obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalization dated to

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient



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 सूचित 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 सूचित 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 रीडंबर्समेंट/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