**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 Account Holder 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 **√** **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.

Aditya Birla Health Insurance Co. Limited

# Claim Form - Part A

For Health Insurance Policies Other Than Travel & Personal Accident

ADITYA BIRLA HEALTH

**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) SI No / Certificate No.

c) Company/ TPA ID No:

d) Name:

e) Address:

City: State: Pin Code:

f) Phone No: g) 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 Y Y

c) If yes, company name:

i) Policy No. ii) Sum Insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No

i) Date: D D M M Y Y Y Y ii) 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: Y Y years M M months

d) Date of Birth: D D M M Y Y Y Y

e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other P L E A S E S P E C I F Y

f ) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other P L E A S E S P E C I F Y

g) Address: (if different from above)

City: State: Pin Code:

h) Phone No: i) E-mail ID:

**DETAILS OF HOSPITALIZATION:**

a) Name of Hospital where Admitted:

b) Room Category Occupied: ☐ Day care ☐ Twin sharing ☐ Single Occupancy ☐ 3 or more beds per room

c) Hospitalization due to: ☐ Injury ☐ Illness ☐ Maternity

d) Date of injury / Date Disease first detected / Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y Y Y

f) Time:

g) Date of Discharge: D D M M Y Y Y Y

h) Time:

i) If Injury give cause: ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption

j) If Medico legal: ☐ Yes ☐ No

k) Reported to police: ☐ Yes ☐ No

l) MLC Report & Police FIR attached: ☐ Yes ☐ No

m) System of Medicine:

**DETAILS OF CLAIM:**

a. Details of the treatment expenses claimed:

i. Pre -hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs.

iii. Post-hospitalization Expenses: Rs. iv. Health-Check up Cost:Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

vii. Total: Rs.

viii. Pre-hospitalization period: days ix. Post -hospitalization period: days

b. Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)

c. Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: Rs. ii. Surgical Cash: Rs.

iii. Critical Illness Benefit: Rs. iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs.

vii. Total Rs.

**Claim Documents Submitted - Check List:**

☐ i. Claim Form Duly signed ☐ ii. Copy of the claim intimation, if any

☐ iii. Hospital Main Bill ☐ iv. Hospital Break-up Bill

☐ v. Hospital Bill Payment Receipt ☐ vi. Hospital Discharge Summary:

☐ vii. Pharmacy Bill ☐ viii. Operation Theatre Notes:

☐ ix. ECG: ☐ x. Doctor's request for investigation:

☐ xi. Investigation Reports (Including CT/ MRI / USG / HPE) ☐ xii. Doctor's Prescriptions:

☐ xiii. Others:

**DETAILS OF BILLS ENCLOSED:**

| Sl. No. | Bill No. | Date | | | Issued by | Towards | Amount (Rs) |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | Hospital Main Bill | |
| 2. | | | | | | Pre-hospitalization Bills: Nos | |
| 3. | | | | | | Post-hospitalization Bills: Nos | |
| 4. | | | | | | Pharmacy Bills | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| 9. | | | | | | | |
| 10. | | | | | | | |

**DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:**

a. Pan No:

b. Account No:

c. Bank Name and Branch:

d. Cheque / DD Payable details:

e. IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

**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: D D M M Y Y Y Y

Place:

Signature of the Insured

| GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured) | | |
|---|---|---|
| DATA ELEMENT | DESCRIPTION | FORMAT |
| **SECTION A - DETAILS OF PRIMARY INSURED** | | |
| a) Policy No. | Enter the policy number | As allotted by the insurance company |
| b) Sl. No/ Certificate No. | Enter the social insurance number or the certificate number of social health insurance scheme | As allotted by the organization |
| c) Company TPA ID No. | Enter the TPA ID No | License number as allotted by IRDA and printed in TPA documents |
| d) Name: | Enter the full name of the policyholder | Surname, First name, Middle name |
| e) Address | Enter the full postal address | Include Street, City and Pin code |
| **SECTION B -DETAILS OF INSURANCE HISTORY** | | |
| a) Currently covered by any other Mediclaim / Health Insurance? | Indicate whether currently covered by another Mediclaim / Health Insurance | Tick Yes or No |
| b) Date of Commencement of first Insurance without break | Enter the date of commencement of first Insurance | Use dd-mm-yyformat |
| c) Company Name | Enter the full name of the insurance company | Name of the organization in full |
| Policy No. | Enter the policy number | As allotted by the insurance company |
| Sum Insured | Enter the total sum insured as per the policy | In rupees |
| d) Have you been Hospitalized in th e last four years since inception of the contract? | Indicate whether hospitalized in the last four years | Tick Yes or No |

| | | |
|---|---|---|
| Date: | Enter the date of hospitalization | Use mm-yy format |
| Diagnosis | Enter the diagnosis details | Open Text |
| e) Previously Covered by any other Mediclaim / Health Insurance? | Indicate whether previously covered by another Mediclaim / Health Insurance | Tick Yes or No |
| f) Company Name | Enter the full name of the insurance company | Name of the organization in full |
| **SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED** | | |
| a) Name | Enter the full name of the patient | Surname, First name, Middle name |
| b) Gender | Indicate Gender of the patient | Tick Male or Female |
| c) Age | Enter age of the patient | Number of years and months |
| d) Date of Birth | Enter Date of Birth of patient | Use dd-mm-yy format |
| e) Relationship to primary Insured | Indicate relationship of patient with policyholder | Tick the right option. If others, please specify. |
| f) Occupation | Indicate occupation of patient | Tick the right option. If others, please specify. |
| g) Address | Enter the full postal address | Include Street, City and Pin Code |
| h) Phone No | Enter the phone number of patient | Include STD code with telephone number |
| i) E-mail ID | Enter e-mail address of patient | Complete e-mail address |
| **SECTION D - DETAILS OF HOSPITALIZATION** | | |
| a) Name of Hospital where admitted | Enter the name of hospital | Name of hospital in full |
| b) Room category occupied | Indicate the room category occupied | Tick the right option |
| c) Hospitalization due to | Indicate reason of hospitalization | Tick the right option |
| d) Date of Injury/Date Disease first detected / Date of Delivery | Enter the relevant date | Use dd-mm-yy format |
| e) Date of admission | Enter date of admission | Use dd-mm-yy format |
| f) Time | Enter time of admission | Use hh:mm format |
| g) Date of discharge | Enter date of discharge | Use dd-mm-yy format |
| h) Time | Enter time of discharge | Use hh:mm format |
| i) If Injury give cause | Indicate cause of injury | Tick the right option |
| If Medico legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported to Police | Indicate whether police report was filed | Tick Yes or No |
| MLC Report & Police FIR attached | Indicate whether MLC report and Police FIR attached | Tick Yes or No |
| j) System of Medicine | Enter the system of medicine followed in treating the patient | Open Text |
| **SECTION E - DETAILS OF CLAIM** | | |
| a) Details of Treatment Expenses | Enter the amount claimed as treatment expenses | In rupees (Do not enter paise values) |
| b) Claim for Domiciliary Hospitalization | Indicate whether claim is for domiciliary hospitalization | Tick Yes or No |
| c) Details of Lump sum/ cash benefit claimed | Enter the amount claimed as lump sum / cash benefit | In rupees (Do not enter paise values) |
| d) Claim Documents Submitted-Check List | Indicate which supporting documents are submitted | Tick the right option |
| **SECTION F - DETAILS OF BILLS ENCLOSED** | | |
| Indicate which bills are enclosed with the amount in rupees | | |
| **SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT** | | |
| a) PAN | Enter the permanent account number | As allotted by the Income Tax department |
| b) Account Number | Enter the bank account number | As allotted by the bank |
| c) Bank Name and Branch | Enter the bank name along with the branch | Name of the Bank in full |
| d) Cheque/ DD payable details | Enter the name of the beneficiary the cheque / DD should be made out to | Name of the individual / organization in full |
| e) IFSC Code | Enter the IFSC code of the bank branch | IFSC code of the bank branch in full |
| **SECTION H - DECLARATION BY THE INSURED** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |

Aditya Birla Health Insurance Co. Limited

# Claim Form - Part B

To Be Filled In By The Hospital

ADITYA BIRLA HEALTH

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)

## 1. 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.:

## 2. DETAILS OF THE PATIENT ADMITTED

a. Name of the Patient:

b. IP Registration Number:

c. Gender: ☐ Male ☐ Female d. Age: Y Y Years M M Months

e. Date of Birth: D D M M Y Y Y Y f. Date of Admission: D D M M Y Y Y Y g. Time:

h. Date of Discharge: D D M M Y Y Y Y i. Time:

j. Type of Admission: ☐ Emergency ☐ Planned Day Care ☐ Maternity

k. If Maternity i) Date of Delivery: D D M M Y Y Y Y ii) Gravida Status:

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

m. Total claimed amount: Rs.

## 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

| a) | ICD 10 Codes | Description | b) | ICD 10 PCS | Description |
|---|---|---|---|---|---|
| i. Primary Diagnosis: | | | i. Procedure 1: | | |
| ii. Additional Diagnosis: | | | ii. Procedure 2: | | |
| iii. Co-morbidities: | | | iii. Procedure 3: | | |
| iv. Co-morbidities: | | | iv. Details of Procedure: | | |

a) Pre-authorization obtained: ☐ Yes ☐ No b) Pre-authorization Number:

c) If authorization by network hospital not obtained, give reason: _____

_____

d) 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.

iv. If not reported to police give reason: _____

_____

**4. CLAIM DOCUMENTS SUBMITTED - CHECK LIST:**

- ☐ a. Claim Form duly signed ☐ b. Original Pre-authorization request
- ☐ c. Copy of the Pre-authorization approval letter ☐ d. Copy of photo ID Card of patient verified by hospital
- ☐ e. Hospital Discharge summary ☐ f. Operation Theatre Notes
- ☐ g. Hospital main bill ☐ h. Hospital break-up bill
- ☐ i. Investigation reports ☐ j. CT/MR/USG/HPE investigation reports
- ☐ k. Doctor's reference slip for investigation ☐ l. ECG
- ☐ m. Pharmacy bills ☐ n. MLC reports & Police FIR
- ☐ o. Original death summary from hospital where applicable
- ☐ p. Any other PLEASE SPECIFY

**5. 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. with State Code:

d. Hospital PAN: e. Number of Inpatient beds:

f. Facilities available in the hospital: OT: ☐ Yes ☐ No ICU: ☐ Yes ☐ No

g. Others:

**6. 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.**

**Date:** DD MM YYYY

**Place:**

**Signature and Seal of the Hospital**

**Authority:**

| GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital) | | |
|---|---|---|
| **DATA ELEMENT** | **DESCRIPTION** | **FORMAT** |
| **SECTION A - DETAILS OF HOSPITAL** | | |
| a) Name of Hospital | Enter the name of hospital | Name of hospital in full |
| b) Hospital ID | Enter ID number of hospital | As allocated by the TPA |
| c) Type of Hospital | Indicate whether In network or non network hospital | Tick the right option |
| d) Name of treating doctor | Enter the name of the treating doctor | Name of doctor in full |
| e) Qualification | Enter the qualification of the treating doctor | Abbreviations of educational qualifications |
| f) Registration No. with State Code | Enter the registration number of the doctor along with the state code | As allocated by the Medical Council of India |
| g) Phone No. | Enter the phone number of doctor | Include STD code with telephone number |
| **SECTION B - DETAILS OF THE PATIENT ADMITTED** | | |
| a) Name of Patient | Enter the name of hospital | Name of hospital in full |
| b) IP Registration Number | Enter insurance provider registration number | As allotted by the insurance provider |
| c) Gender | Indicate Gender of the patient | Tick Male or Female |
| d) Age | Enter age of the patient | Number of years and months |
| e) Date of Birth | Enter date of birth of the patient | Use dd-mm-yy format |
| f) Date of Admission | Enter date of admission | Use dd-mm-yy format |
| g) Time | Enter time of admission | Use hh:mm format |
| h) Date of Discharge | Enter date of discharge | Use dd-mm-yy format |
| i) Time | Enter time of discharge | Use hh:mm format |
| j) Type of Admission | Indicate type of admission of patient | Tick the right option |
| k) If Maternity | | |
| Date of Delivery | Enter Date of Delivery if maternity | Use dd-mm-yy format |
| Gravida Status | Enter Gravida status if maternity | Use standard format |
| l) Status at time of discharge | Indicate status of patient at time of discharge | Tick the right option |
| m) Total claimed amount | Indicate the total claimed amount | In rupees (Do not enter paise values) |
| **SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)** | | |
| a) ICD 10 Code | | |
| Primary Diagnosis | Enter the ICD 10 Code and description of the primary diagnosis | Standard Format and Open text |
| Additional Diagnosis | Enter the ICD 10 Code and description of the additional diagnosis | Standard Format and Open text |
| Co-morbidities | Enter the ICD 10 Code and description of the co -morbidities | Standard Format and Open text |
| b) ICD 10 PCS | | |
| Procedure 1 | Enter the ICD 10 PCS and description of the first procedure | Standard Format and Open text |
| Procedure 2 | Enter the ICD 10 PCS and description of the second procedure | Standard Format and Open text |
| Procedure 3 | Enter the ICD 10 PCS and description of the third procedure | Standard Format and Open text |
| Details of Procedure | Enter the details of the procedure | Open text |
| c) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| d) Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| e) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| f) Hospitalization due to injury | Indicate if hospitalization is due to injury | Tick Yes or No |
| Cause | Indicate cause of injury | Tick the right option |
| If injury due to substance abuse/alcohol consumption, test conducted to establish this | Indicate whether test conducted | Tick Yes or No |
| Medico Legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported To Police | Indicate whether police report was filed | Tick Yes or No |

| | | |
|---|---|---|
| FIR No. | Enter first information report number | As issued by police authorities |
| If not reported to police, give reason | Enter reason for not reporting to police | Open Text |
| **SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST** | | |
| Indicate which supporting documents are submitted | | |
| **SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL** | | |
| a) Address | Enter the full postal address | Include Street, City and Pin Code |
| b) Phone No. | Enter the phone number of hospital | Include STD code with telephone number |
| c) Registration No. with State Code | Enter the registration number of the doctor along with the state code | As allocated by the Medical Council of India |
| d) Hospital PAN | Enter the permanent account number | As allocated by the Income Tax department |
| e) Number of Inpatient beds | Enter the number of inpatient beds | Digits |
| f) Facilities available in the hospital | Indicate facilities available in the hospital | Tick the right option. If others, please specify |
| **SECTION F - DECLARATION BY THE HOSPITAL** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp | | |

Paramount Health
Your link to good health

# 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 Heath Insurance Policy
## (स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I declare that I do not have any health insurance policy.
( मैं घोषणा (खुलासा) करता हूं कि मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I declare that I have health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास एक स्वास्थ्य बीमा पॉलिसी है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Does not have insurance coverage 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 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 has health insurance coverage 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 लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि 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