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.

HDFC ERGO General Insurance Company Limited

GROUP MEDICLAIM INSURANCE

INSURED'S INFORMATION

Name of Policyholder:

Policy No.: Certificate No.: (If applicable)

CLAIMANT INFORMATION

Name of Patient:

Occupation: Date of Birth: D D M M Y Y Y Y Present completed age:_____

Address and phone number:

Relationship to the Policyholder: ☐ Member/ Employee ☐ Spouse ☐ Dependent Child ☐ Dependent Mother ☐ Dependent Father

1. Nature of sickness/ diseaes/ injury claimed for: _____

   Date on which Injury was sustained or disease or illness first detected: D D M M Y Y Y Y Date of first consultation: D D M M Y Y Y Y

   Name of Doctor:

   Address, Phone No. of Doctor:

   Qualification of the Doctor consulted:

2. Have you had any prior treatment for this or related conditions? ☐ Yes ☐ No

   Name of Doctor:

   Address, Phone No. of Doctor:

   Qualification of the Doctor: Date: D D M M Y Y Y Y

3. Are you making any other insurance claim as a result of this hospitalization/surgery?: ☐ Yes ☐ No

   Name of Insurance Company:

   Policy No.:

4. Was the hospitalization/ surgery a result of an accident? ☐ Yes ☐ No

5. Place of Accident: Date of Accident: D D M M Y Y Y Y

6. Details of hospitalisation:

   Name of Hospital/ Nursing Home:

   Address:

   Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

7. CLAIM QUANTUM:

Date	Nature of expenses incurred	Billed By	Amount (₹)
		Total	

(If space is insufficient, please attach separate list)

In support of the above claim, I enclose the following original documents (Please tick)

- ☐ Hospital Discharge Card
- ☐ Bills, Cash Memos, Receipt from Hospitals
- ☐ Cash Memos, Receipts from Pharmacists, Pathology and Investigation Centres
- ☐ Bills, Cash Memos, Receipts from attending Doctors, Surgeons, Anesthetists
- ☐ Doctor's prescriptions for medicines, pathological tests, hospitalisation, surgery, physiotherapy
- ☐ Any other documents. Please specify

I/ We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance.

AUTHORISATION

I HEREBY AUTHORISE on behalf of the patient: (1) Any empl oyer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorisation shall bind the patient's successors and remains valid notwithstanding death or incapacity. A photocopy or facsimile copy of this authorisation shall be as valid as the original.

Date: D D M M Y Y Y Y

Place:

Signature of Patient

This is to certify that the above-mentioned claim lodged by the Insured / Claimant is genuine and the same is recommended for reimbursement.

Date: D D M M Y Y Y Y

Place:

Authorised Signatory

Name of Attending Physician:

Address, Phone No.:

I certify that the above named patient _____, was seen by me on _____ and has been fully cured of the sickness/injury claimed for, which first incurred on _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Date: D D M M Y Y Y Y

Place:

SIGNED (Attending Physician)

Name of the Policy holder & Seal:

Date: D D M M Y Y Y Y

ATTENDING PHYSICIAN INFORMATION

HDFC ERGO General Insurance Company Limited

Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment (Please tick for mode of payment) Cheque ☐ Fund Transfer ☐

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments
In Support of Bank Details
(Please tick the type of proof submitted) Cancelled Cheque ☐ Bank Passbook Copy ☐

Declaration: I Mr./ Mrs/ Ms. _____ undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary
Stamp Required in case of Company

Date: D D M M Y Y Y Y