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.

CLAIM FORM - PART B
TO BE FILLED 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 liu of PART A

HDFC Life
Sar utha ke jiyo!

(To be filled inblock letters)

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: SURNAME FIRST NAME MIDDLE NAME
e. Qualification: **f.** Registration No. with State Code:
g. Phone No.:

DETAILS OF THE PATIENT ADMITTED:

a. Name of the patient: SURNAME FIRST NAME MIDDLE NAME
b. IP Registration No.: **c.** Gender: Male ☐ Female ☐ **d.** Age (years): YYMM **e.** Date of Birth: DDMMYY
f. Date of Admission: DDMMYY **g.** Time: HHMM **h.** Date of Discharge: DDMMYY **i.** Time: HHMM
j. Type of admission: Emergency ☐ Planned ☐ Day Care ☐ **k.** If Maternity i. Date of delivery: DDMMYY ii. Gravida Status:
l. Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Diseased ☐
m. Total claimed ammount:

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. Pre-authorization obtained: ☐ Yes ☐ No **d.** Pre-authorization Number:
e. If authorization by network hospital not obtained, give reason: _____
f. 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: _____

CLAIM DOCUMENTS SUBMITTED - CHECK LIST:

- ☐ Claim Form Duly Signed
- ☐ CT/MRI/USG/HPE investigation Reports
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Pharmacy Bills
- ☐ Hospital Main Bill
- ☐ Any Other, please specify
- ☐ Investigation Reports
- ☐ Copy of the Pre-authorization approval letter
- ☐ ECG
- ☐ Operation Theatre Notes
- ☐ Original death summary from hospital where applicable
- ☐ Original Pre-authorization request
- ☐ Doctor's reference slip for investigation
- ☐ Hospital Discharge Summary
- ☐ MLC reports & Police FIR
- ☐ Hospital Break-up Bill

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: i. OT: Yes No ii. ICU: Yes No

iii. Others: _____

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished this Claim Form is true & correct to the best of my 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 forfieted.

Date: D D M M Y Y Place: _____ Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To Be Filled 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 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 qualifications of treating doctor	Abbreviations of educational qualifications
f. Registration	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 full name of the patient	Name of hospital in full
b. IP registration Number	Enter insurance provider registration number	As allocated 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	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 hh:mm 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	Enter status of patient at time of discharge	Tick the right option
m. Total claimed amount	Indicate the total claimed ammount	In rupees (Do not enter paise values)

SECTION C - DETAILS OF THE 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 the 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 the Pre-authorization Number	As allocated by TPA
e. If authorization by network hospital not obtained, give reason	Enter reason for not obtaining Pre-authorization number	Open Text
f. Hospitalisation due to injury	Indicate if hospitalisation 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	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text

SECTION D - DETAILS OF THE AILMENT DIAGNOSED (PRIMARY)

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 allotted by the Income Tax department
e. Number of Inpatient beds	Enter the number of Inpatient beds	Digits
f. Facilities available in hospital	Indicate facilities available in the hospital	Tick the right option, if others, please specify

SECTION F - DETAILS OF THE AILMENT DIAGNOSED (PRIMARY)

Read declaration carefully and mention the date (in dd:mm:yy format), place (open text) and sign and stamp