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.

RELIANCE GENERAL INSURANCE

reliancegeneral.co.in
022 4890 3009 (Paid)
74004 22200

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

(To be filled in BLOCK LETTERS)

TO BE FILLED IN BY THE INSURED

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

SECTION A - DETAILS OF PRIMARY INSURED

a) Type of claim

☐ Hospitalization ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Health check-up ☐ OPD

b) Pre authorization obtained ☐ Yes ☐ No

c) Policy type ☐ Individual ☐ Group

d) Group/Company name

e) Policy No f) Sl. No/Certificate No

g) Company/TPA ID No. h) Name

I) Address

City State Pincode

Phone No Email ID.

j) PAN No

k) Monthly Income: ☐ Up to ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above

SECTION B - 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

Policy No Sum Insured ₹

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

Date d d m m Diagnosis

e) Previously covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

f) If yes Company Name

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED

a) Name

b) Gender ☐ Male ☐ Female c) Age - _____ years _____Months d) Date of birth d d m m y y y y

e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother Other - Please Specify

f) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Other - Please Specify

g) Address (if different from above)

City State Pin Code

Phone No Email Id

SECTION D - DETAILS OF HOSPITALIZATION

a) Name of Hospital where admitted _____

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 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 H H M M

g) Date of discharge d d m m y y y y h) Time H H M M

I) If injury give cause: ☐ Self inflicted ☐ Road traffic accident ☐ Substance abuse /Alcohol consumption

I) If Medico legal ☐ Yes ☐ No ii) Reported to police ☐ Yes ☐ No

iii) MLC report & Police FIR attached ☐ Yes ☐ No j) System of medicine _____

SECTION E - DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre hospitalization expenses ₹ _____ ii. hospitalization expenses ₹ _____

iii. Post hospitalization expenses ₹ _____ iv. Health check up cost ₹ _____

v. Ambulance charges ₹ _____ vi. Others(code) ₹ _____

TOTAL ₹ _____

vii. Pre hospitalization period _____ days viii. 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 ₹ _____/- ii Surgical cash ₹ _____/-

iii Critical illness benefit- ₹ _____/ iv Convalescence ₹ _____/-

v. Pre/Post hospitalization Lump sum benefit ₹ _____/- vi Others ₹ _____/-

TOTAL ₹ _____/-

SECTION F - DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date	Issued By	Towards	Amount ₹)
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	
5		d d m m y y y y		Other expenses if any _____	
6		d d m m y y y y			
7		d d m m y y y y			
8		d d m m y y y y			
9		d d m m y y y y			
10		d d m m y y y y			

CLAIM DOCUMENTS SUBMITTED CHECK LIST

S.No	Documents
1	☐ Claim form duly signed
2	☐ Copy of the claim intimation, if any
3	☐ Hospital main bill
4	☐ Hospital break up bill
5	☐ Hospital bill payment receipt
6	☐ Hospital discharge summary
7	☐ Pharmacy bill
8	☐ Operation theatre notes
9	☐ ECG
10	☐ Doctor's request for investigation
11	☐ Investigation reports (including CT/MRI/USG/HPE)
12	☐ Doctor's prescriptions
13	☐ Others

As per policy terms & conditions, the Company reserves its right to have the Insured examined by a Doctor appointed by it for verification of diagnosis.

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

1. Name of the Bank Account Holder ☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T
2. Bank Account No.:
3. Account: ☐ Saving ☐ Current ☐ Other
4. Name of the Bank
5. Branch
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
7. IFSC Code (11 character code appearing on your cheque leaf)

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

SECTION H - DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I made any false or untrue statement, suppression or concealment of any material fact with respects to questions asked in relation to the claimed, 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 ______________________