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 - PART B

(To be filled in BLOCK LETTERS)

TO BE FILLED IN 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 lieu of PART A

SECTION A - 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

I) Email Id:

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient

b) IP Registration Number

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

e) Date of Admission d d m m y y y y g) Time H H M M

h) Date of Discharge d d m m y y y y i) Time H H M M

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 ₹ /-

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part A

S.No	ICD 10 Codes	Description
1	Primary Diagnosis	
2	Additional Diagnosis	
3	Co-morbidities	
4	Co-morbidities	

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part B

S.No	ICD 10 PCS	Description
1	Procedure 1	
2	Procedure 2	
3	Procedure 3	
4	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 _____

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

S.No		Documents	S.No		Documents
1	☐	Claim form duly signed	9	☐	Investigation reports
2	☐	Original pre authorization request	10	☐	CT/MRI/USG/HPE investigation reports
3	☐	Copy of pre - authorization approval letter	11	☐	Doctor's reference slip for investigation
4	☐	Copy of photo ID card of patient verified by hospital	12	☐	ECG
5	☐	Hospital discharge summary	13	☐	Pharmacy bills
6	☐	Operation theatre notes	14	☐	MLC report & police FIR
7	☐	Hospital main bill	15	☐	Original death summary from hospital where applicable
8	☐	Hospital break up bill	16	☐	Any other, please specify

SECTION E - 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 Inpatients bed _____

f) Facilities available in the hospital i) OT ☐ Yes ☐ No ii) ICU ☐ Yes ☐ No iii) Others _____

SECTION F - DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in the 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 forfeited.

Date d d m m y y y y Place _____ Signature & Seal of Hospital Authority _____