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.

SBI General INSURANCE

Call (Toll Free)
1800 22 1111 | 1800 102 1111
www.sbigeneral.in

HEALTH INSURANCE POLICY - RETAIL

Claim Form

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

Policy No. ______________ Claim No. ______________

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Insured — SURNAME / MIDDLE NAME / FIRST NAME
2. Name of the Claimant — SURNAME / MIDDLE NAME / FIRST NAME
3. Relationship with Insured ______ Date of Birth D D M M Y Y Y Y
4. Gender ☐ Male ☐ Female Health Card No.: ______
5. Contact Details
   - House No. ______ Block ______
   - Building ______ Locality ______
   - Street ______
   - City ______ District ______
   - State ______ Pincode ______
   - Phone No. ______ Mobile ______
   - Email ID ______

B. DETAILS OF ILLNESS/ACCIDENT

1. Signs and symptoms of illness ______
2. Nature of disease/illness/injury ______
3. Diagnosis of illness ______
4. When did you first notice signs and symptoms of the illness? D D M M Y Y Y Y
5. When did you first consult your doctor for the illness? D D M M Y Y Y Y
5. When was the illness first diagnosed/detected? D D M M Y Y Y Y
6. Have you ever had the similar illness in past? ☐ Yes ☐ No
   If 'Yes', provide details, ______
7 Any other past history? ______
8 Name of the Doctor consulted first for this illness ______
8.1 Contact Details of the Doctor
   - Phone No. ______ Mobile ______
   - E-mail Id ______
9. Date & Time of Admission D D M M Y Y Y Y ___ : ___ A.M. / P.M.
10. Date & Time of Discharge D D M M Y Y Y Y ___ : ___ A.M. / P.M.

Version 1.0, June 2012

11. Type of Admission ☐ Emergency ☐ Planned ☐ Daycare

12. Type of Claim ☐ Hospitalization - Illness ☐ Hospitalization - Accidental ☐ Hospitalization - Domiciliary ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Parental Care Benefit ☐ Child Care Benefit ☐ Convalescence Benefit

13. Type of Hospital ☐ Network ☐ Non-Network

14. Type of Treatment ☐ Allopathic ☐ Ayurvedic ☐ Homeopathic ☐ Unani

15. Name of the Hospital

16. Name of treating Doctor

17. Qualification of treating Doctor Treating Doctors Registration No.

18.1Address of the Hospital Plot No/Door No. Building Name

Road Area

City District

State Pincode

18.2Contact Details Phone No. Mobile

E-mail Id

19. Name, address & telephone no. of Family Doctor

C. DETAILS OF PREVIOUS HEALTH CLAIM

1. Have you incurred any claim before? ☐ Yes ☐ No

If 'Yes', please provide details ____________________

D. DETAILS OF OTHER HEALTH INSURANCE/INTEREST

1. Is the illness / disease covered under any other Insurance? ☐ Yes ☐ No

If 'Yes', specify details and attach copy of the said Policy

Name of Insurer

Policy Number

Name of TPA

E. SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT UNDER HOSPITALIZATION

1. Please tick (✓) specifying nature of claim as follows along with the expense details:

Sr. No.	Expense Details	Amount (Rs.)
A	Hospitalization Expenses	
B	Pre-hospitalization Expenses	
C	Post-hospitalization Expenses	
D	Day Care Hospitalization	
E	Domiciliary Treatment expenses	
F	Maternity Expenses	
G	Emergency Ambulance Expenses	
H	Other expenses not included above	
I	Other expenses not included above	
	Total Amount Claimed	

Please provide break up of expenses incurred by claimant

Description	Claimed Amount (Rs.)
Room and Board Expenses (No. of days x Amount / day)	
Intensive Care Unit Expenses (No. of days x Amount / day)	
Investigations Expense	
Medicines Expense	
Doctor Consultation / Visit Expense	
Surgeon Expense	
Anesthetist Expense	
Operation Theatre Expense	
Consumables Expense	
Registration / Service Expense	
Ambulance Expenses	
Parental Care Benefit	
Child Care Benefit	
Convalescence Benefit	
Other Expenses not included above	
Other Expenses not included above	
GRAND TOTAL	

F. ENCLOSURE CHECKLIST

- ☐ Claim Form duly filled & signed
- ☐ Policy Copy
- ☐ Discharge Card / Certificate
- ☐ Hospitalization Bills
- ☐ Medicine Bills
- ☐ Investigation Bills
- ☐ Valid Photo Identity Card
- ☐ Medical Certificate
- ☐ FIR/ MLC copy
- ☐ Death Certificate (if applicable)
- ☐ Investigation Reports
- ☐ Doctor's Prescription
- ☐ Any other documents

Any other documents, please specify ______________________________

G PAYEE DETAILS

1. Name of Proposer
2. Payable Details ☐ Cheque ☐ NEFT

Bank Name | Bank Branch

Bank Account No. | IFSC Code

MICR No. | PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account.

H. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐ Yes ☐ No

If 'Yes', specify

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

Place ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Signature of Claimant ____________________

Date: D D M M Y Y Y Y Name of Insured/Claimant ____________________

I. DETAILS TO BE FILLED BY HOSPITAL

1. Name of the patient ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   IP Registration No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Description

a. Primary Diagnosis ____________________

b. Additional Diagnosis ____________________

c. Procedure 1 ____________________

d. Procedure 2 ____________________

e. Procedure 3 ____________________

f. Details of Procedure ____________________

2. Pre-authorization Obtained ☐ Yes ☐ No

   If Yes, Pre-authorization No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   If authorization is not obtained by network hospital please give reason ____________________

   Is Hospitalization due to injury? ☐ Yes ☐ No

   If Yes, ☐ Self inflicted ☐ RTA ☐ Any Other

   If injury due to substance abuse / alcohol consumption? ☐ Yes ☐ No

   Was test conducted to establish substance abuse? ☐ Yes ☐ No

   Medico legal ☐ Yes ☐ No

   Reported to police ☐ Yes ☐ No

   FIR No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   If not reported to Police give reason ____________________

I certify that I have examined the above named insured, the above statements are correct and that the above named insured is necessarily suffered from the illness mentioned.

Place ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Stamp and Signature of the Hospital Authority ☐

Date: D D M M Y Y Y Y