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.0 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.		
1.a	Policy Declaration Form duly signed by the Insured & Hospital 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 AccountHolder 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 cofTPA, 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 Des!	**Signature:**	

Important Points to Remember:-

1. Please mark either **V** **or** x 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.

Health Claim Form

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.:
b) Sl. No./ Certificate No.:
c) Company/ TPA ID No.:
d) Name: SURNAME FIRST NAME MIDDLE NAME
e) Address:
City: State:
Pin Code: Phone No.: Email ID:

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: DD MM YYYY
c) If yes, Company Name:
Policy No.:
Sum Assured (₹):
d) Have you been hospitalised in last four years since inception of the contract? ☐ Yes ☐ No
Date: MM YYYY Diagnosis:
e) Previously covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No
f) If Yes, Company Name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALISED

a) Name: SURNAME FIRST NAME MIDDLE NAME
b) Gender: ☐ Male ☐ Female c) Age: MM YYYY d) Date of Birth: DD MM YYYY
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 HOSPITALISATION

a) Name of Hospital where admitted:
b) Room Category Occupied: ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room
c) Hospitalisation due to: ☐ Injury ☐ Illness ☐ Maternity
d) Date of Injury/ Date Disease first detected/ Date of Delivery: DD MM YYYY
e) Date of Admission: DD MM YYYY f) Time: HH MM
g) Date of Discharge: DD MM YYYY h) Time: HH MM
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:

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i) Pre-hospitalisation Expenses: ₹

ii) Hospitalisation Expenses: ₹

iii) Post-hospitalisation Expenses: ₹

iv) Health-Check up Cost: ₹

v) Ambulance Charges: ₹

vi) Others (code): ₹

Total: ₹

vii) Pre-hospitalisation Period: Days

viii) Post-hospitalisation Period: Days

b) Claim for Domiciliary Hospitalisation ☐ 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 Hospitalisation Lump sum benefit: ₹

vi) Others: ₹

Total: ₹

SECTION E

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

☐ Claim Form Duly Signed
☐ Copy of the Claim Intimation (if any)
☐ Hospital Main Bill
☐ Hospital Break-up Bill
☐ Hospital Bill Payment Receipt
☐ Hospital Discharge Summary
☐ Pharmacy Bill
☐ Operation Theatre Notes
☐ ECG
☐ Doctor's Request for Investigation
☐ Investigation Reports (Including CT/ MRI/ USG/ HPE)
☐ Doctor's Prescriptions
☐ Others

DETAILS OF BILLS ENCLOSED

Sl. No	Bill No.	Date	Issued by	Towards	Amount (₹)
1.		DDMMYYYY		Hospital Main Bill	
2.		DDMMYYYY		Pre-hospitalisation Bills:________Nos.	
3.		DDMMYYYY		Post-hospitalisation Bills:________Nos.	
4.		DDMMYYYY		Pharmacy Bills	
5.		DDMMYYYY			
6.		DDMMYYYY			
7.		DDMMYYYY			
8.		DDMMYYYY			
9.		DDMMYYYY			
10.		DDMMYYYY			

SECTION F

DETAILS OF PRIMARY INSURED'S BANK ACCOUNTS

a) PAN:

b) Account Number:

c) Bank Name:

Branch:

d) Cheque / DD Payable Details:

e) IFSC Code:

SECTION G

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 have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and authorise 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 and that I will not be making any supplementary claim except the pre/ post-hospitalisation claim, If any.

Date: DDMMYYYY Place: Signature of Insured

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)

DATA ELEMENT	DESCRIPTION	FORMAT
Section A - Details of the Primary Insured		
a) Policy No.	Enter the Policy Number	As allotted by the Insurance Company
b) Sl. No./ Certificate No.	Enter the Social Insurance Number or the certificate number of social health insurance scheme	As allotted by the Organisation
c) Company TPA ID No.	Enter the TPA ID No.	License number, as allotted by the IRDA and printed in TPA documents
d) Name	Enter the full name of the Policy Holder	Surname, First name, Middle name
e) Address	Enter the full Postal Address	Include Street, City and PIN Code
Section B - Details of Insurance History		
a) Currently covered by any other Mediclaim / Health Insurance	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick 'Yes' or 'No'
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use DD-MM-YYYY format
c) Company Name	Enter the full name of the Insurance Company	Name of the Organisation in full
Policy No.	Enter the Policy Number	As allotted by the Insurance Company
Sum assured	Enter the total sum insured as per the policy	In rupees
d) Have you been hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick 'Yes' or 'No'
Date	Enter the date of hospitalisation	Use DD-MM-YYYY format
Diagnosis	Enter the diagnosis details	Open text
e) Previously covered by any other Mediclaim / Health Insurance	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick 'Yes' or 'No'
f) Company Name	Enter the full name of the Insurance Company	Name of the Organisation in full
Section C - Details of Insured Person Hospitalised		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate gender of the patient	Tick 'Male' or 'Female'
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use DD-MM-YYYY format
e) Relationship to Primary Insured	Indicate relationship of patient with Policy Holder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
g) Address	Enter the full postal address	Include Street, City and PIN Code
h) Phone No.	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
Section D - Details of Hospitalisation		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d) Date of Injury/ Date Disease first detected/ Date of Delivery	Enter the relevant date	Use DD-MM-YYYY format
e) Date of admission	Enter the date of admission	Use DD-MM-YYYY format
f) Time	Enter the time of admission	Use HH:MM format
g) Date of discharge	Enter date of discharge	Use DD-MM-YYYY format
h) Time	Enter the time of discharge	Use HH:MM format
i) If Injury, give cause	Indicate cause injury	Tick the right option
If 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'
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick 'Yes' or 'No'
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open text
Section E - Details of Claim		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	Tick 'Yes' or 'No'
c) Details of Lump sum/ Cash benefit claimed	Enter the amount claimed as Lump sum/ Cash benefit	In rupees (Do not enter paise values)
d) Claim Document Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
Section F - Details of Bill Enclosed		
Indicate which bills are enclosed with the amounts in rupees		
Section G - Details of Primary Insured's Bank Accounts		
a) PAN	Enter the Permanent Account Number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank Account Number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary, the Cheque / DD should be made out to	Name of the Individual / Organisation in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
Section H - Declaration by the Insured		
Read declaration carefully and mention date (in DD-MM-YYYY format), place (open text) and sign.		

CLAIM FORM - PART B
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 preauthorisation request form in lieu of PART A (To be filled in block letters)

DETAILS OF HOSPITAL

SECTION A

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

SECTION B

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME
b) IP Registration Number: c) Gender: ☐ Male ☐ Female
d) Age: YY Years MM Months e) Date of Birth: DDMMYYYY
f) Date of Admission: DDMMYYYY g) Time: HH MM
h) Date of Discharge: DDMMYYYY i) Time: HH MM
j) Type of Admission: ☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity
k) If Maternity: i) Date of Delivery: DDMMYYYY ii) Gravida Status:
l) Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deseased
m) Total claimed amount:

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

SECTION C

a) ICD 10 Codes — Description
   i) Primary Diagnosis:
   ii) Additional Dignosis:
   iii) Co-morbidities:
   iv) Co-morbidities:
b) ICD 10 PCS — Description
   i) Procedure 1:
   ii) Procedure 2:
   iii) Procedure 3:
   iv) Details of Procedure:
c) Pre-authorisation obtained: ☐ Yes ☐ No d) Pre-authorisation Number:
e) If authorisation by network hospital not obtained, give reason:
f) Hospitalisation 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 report)
   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

SECTION D

- ☐ Claim Form Duly Signed
- ☐ Original Pre-authorisation request
- ☐ Copy of the Pre-authorisation Approval Letter
- ☐ Copy of Photo ID Card of Patient Verified by Hospital
- ☐ Hospital Discharge Summery
- ☐ Operation Theatre Notes
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Investigation Reports
- ☐ CT / MRI / USG / HPE Investigation Reports
- ☐ Doctor's Reference Slip for Investigation
- ☐ ECG
- ☐ Pharmacy Bill
- ☐ MLC Reports & Police FIR
- ☐ Original Death Summary from Hospital Where Applicable
- ☐ Any other, Please Specify

DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of Non-netwok Hospital)

SECTION E

a) Address of the Hospital:

City: State:

Pincode:

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:

SECTION F

We hereby declare that the information furnished in this claim form is true and correct to the best of our 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 and Seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)

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 the TPA
c) Type of Hospital	Indicate whether in network or non-network hospital	Tick the right option
d) Name of the treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration Number with State Code	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 the doctor	Include STD code with telephone number
Section B - Details of Patient Admitted		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider's registration number	As allotted by the insurance provider
c) Gender	Indicate gender of the Patient	Tick 'Male' or 'Female'
d) Age	Enter the age of Patient	Number of years and months
e) Date of Birth	Enter the Date of Birth	Use DD-MM-YYYY format
f) Date of Admission	Enter the Date of Admission	Use DD-MM-YYYY format
g) Time	Enter the time of Admission	Use HH-MM format
h) Date of Discharge	Enter the Date of Discharge	Use DD-MM-YYYY format
I) Time	Enter the 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 the Date of Delivery, if maternity	Use DD-MM-YYYY format
Gravida Status	Enter Gravida Status, if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
Section C - Details of Ailment Diagnosed (Primary)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the Primary Diagnosis	Standard format & Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the Additional Diagnosis	Standard format & Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard format & Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the First Procedure	Standard format & Open text
Procedure 2	Enter the ICD 10 PCS and description of the Second Procedure	Standard format & Open text
Procedure 3	Enter the ICD 10 PCS and description of the Third Procedure	Standard format & Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorisation obtained	Indicate whether Pre-authorisation obtained	Tick 'Yes' or 'No'
d) Pre-authorisation number	Enter the Pre-authorisation number	As allotted by the TPA
e) If authorisation by network hospital not obtained, give reason	Enter reason for not obtaining Pre-authorisation number	Open text
f) Hospitalisation due to injury	Indicate if hospitalisation is 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 number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
Section D - Claim Documents Submitted Checklist		
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 state code	As allotted 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 the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
Section F - Declaration by the Hospital		
Read declaration carefully and mention Date (in DD-MM-YYYY format) and Place (open text), along with Sign and Stamp.		

Paramount Health
Your link to good health

POLICY DECLARATION FORM

Date:……

Name of the Hospital :……

Address:……

PATIENT NAME (BLOCK LETTERS):…… AGE/SEX :……

Mobile No of Patient:……

Date of Admission:…… Date of Discharge:……

Undertaking by the Patient regarding Heath Insurance Policy
(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I declare that I do not have any health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I declare that I have health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास एक स्वास्थ्य बीमा पॉलिसी है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Does not have insurance coverage hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)

- Patient has health insurance coverage but out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature: ……

Name of the Hospital Representative & Hospital Seal