## 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 CLATM 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 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 Document Remarks Status(Y/N) IRDA Claim Form duly signed by the Insured & Hospital 1 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. Policy Declaration Form duly signed by the Insured & Hospital hospitals. 1.a In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same. Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the AccountHolder Printed on the Cheque 3 Leaf. ID Proof of Employee / Primary Insured- Any of one (Passport, Voter ID, Driving License, Or any Government 4 Approved ID ) . If Claim is above 1 lakh- PAN is mandatory with address Proof ID Proof of Patient- Any of one (Passport, Voter ID, Driving License, Or any Government Approved ID) 5 Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care 6 Freatment) / Death Summary (in Case of Death Claim) Copy of the Legal heir certificate (if the claim is for the death of the principle insured) 6.a Copy of Post Mortem Report & Death Certificate (In Accidental Death cases) 6.b Policy Copy ( if individual policy) 8 64VB Compliance Certificate ( If individual policy) Original Final Hospital bill with cost wise breakup of each Item q Original Payment Receipt of Main Hospital bill ( both Deposit / Refund) Receipt Of Payments made at the Hospital by Credit Card: Please attach the Xerox Copy of the Credit Card Payment 10.a 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 Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions. 13 14 Original copy of First Consultation letter and subsequent Prescriptions. ospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not 15 falls in GIPSA/PPN ) OTHER DOCUMENTS 16 Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim) 16.a 16.h Original Sonography Report in case of Maternity Claim Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract 16.c Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in 16.d case of Road Traffic Accident (RTA) A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along 16.e with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases) In case of claims where the insured has submitted documents to another insurance cofTPA, he needs to submit 16.f 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 DD /MM/YYYY HH:MM PHS Executive

Important Points to Remember:
1. Please mark either V or x against respective check box

PHS - (Location) / Help Des!

Submission:

Claim Submitted at:

- 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

Name:

Signature:

- 5. Please visit us at <a href="https://www.paramounttpa.com">www.paramounttpa.com</a> 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.

## CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Claims Processing Centre: Hari Nivas Towers, Second Floor, 163, Thambu Chetty Street, Parry's Corner , Chennai-600001 Toll Free Ph no: 1800 200 5544 Toll Free Fax no: 1800 425 2200 e-mail:Customercare@cholams.murugappa.com;





e-mail:Customercare@cholams.murugappa.com;

www.cholainsurance.com

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

All reimbursement claims either from network / non-network hospitals has to be intimated immediately to us at the earliest (before discharge) to our customer care through care through Toll Free number 18002005544 or by an e-mail to help@choalms.murugappa.com Claim documents should be submitted to us within 30 days from the date of discharge. The issuance of this form does not imply Admission of Liability. Please answer questions completely. Use additional sheet, if required. Please attach the documents required as indicated. Please note that the list of documents mentioned is an indicative list, We may ask for any other documents to process the claim.

DETAILS OF PRIMARY INSURED:	
a) Policy No:	
d) Name: SURNAME FIRST NAME MID	
e) Address :	
City: State: State:	
Pin Code: Phone No: Email ID:  DETAILS OF INSURANCE HISTORY:	
a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break:	M Y (Copies of Policies to be attached)
c) If yes, company name; Policy No. Policy No.	
Sum Insured (Rs.)	nosis:
e) Previously covered by any other Mediclaim / Health insurance : Yes No f) If yes, Company Name	nosis:
DETAILS OF INSURED PERSON HOSPITALIZED:	
a) Name:	
b) Gender: Male Female c) Age: years Y Y months M M d) Date of Birth: D D M M 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):	
9) 10001000 (10 01010101010101010101010101	
City: State: Sta	
Pin Code: Phone No: E-mail ID:	
DETAILS OF HOSPITALIZATION:	
a) Name of Hospital where Admitted:	
b) Room Category occupied: Day care Suite Deluxe Room 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	M M Y Y Y
e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M	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:	
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine:	
k) Type of hospitalization: Emergency / Planned	
k) Type of hospitalization: Emergency / Planned DETAILS OF CLAIM:	
k) Type of hospitalization: Emergency / Planned	Claim Documents Submitted- Check List:
k) Type of hospitalization: Emergency / Planned	Claim Documents Submitted- Check List:
k) Type of hospitalization: Emergency / Planned	Claim Documents Submitted- Check List:
k) Type of hospitalization: Emergency / Planned DETAILS OF CLAIM:  a) Details of the treatment expenses claimed  i. Pre-hospitalization Expenses: Rs.   ii. Hospitalization Expenses: Rs.   iii. Post-hospitalization Expenses: Rs.   iv. Health-Check up Cost: Rs.   iii. Post-hospitalization Expenses: Rs.   iv. Health-Check up Cost: Rs.   iii. Post-hospitalization Expenses: Rs.   iv. Health-Check up Cost: Rs.   iii. Post-hospitalization Expenses: Rs.	Claim Documents Submitted- Check List:    Filled claim form duly signed   Copy of the claim intimation   Final Hospital Bill with detailed break-up   Hospital bill payment receipt
k) Type of hospitalization: Emergency / Planned	Claim Documents Submitted- Check List:    Filled claim form duly signed   Copy of the claim intimation   Final Hospital Bill with detailed break-up   Hospital bill payment receipt
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k) Type of hospitalization: Emergency / Planned  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed  i. Pre-hospitalization Expenses: Rs.	Claim Documents Submitted- Check List:  Filled claim form duly signed  Copy of the claim intimation  Final Hospital Bill with detailed break-up  Hospital bill payment receipt  Detailed hospital discharge summary  Pharmacy / medical bills which supporting doctor prescription  Investigation / lab reports supporting the diagnosis.  Operation theatre notes for surgical cases  Invoice / sticker for the implants used in the treatment.
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Note   Pre-hospitalization   Emergency   Planned   DETAILS OF CLAIM:	Claim Documents Submitted- Check List:  Filled claim form duly signed  Copy of the claim infirmation  Final Hospital Bill with detailed break-up  Hospital bill payment receipt  Detailed hospital discharge summary  Pharmacy / medical bills which supporting doctor prescription  Investigation / lab reports supporting the diagnosis.  Operation theatre notes for surgical cases  Invoice / sticker for the implants used in the treatment.  External Aids vendors supported by the proper prescription from Doctor.  Home Hospitalization treatment - Certificate from teating doctor specifying reasons for Home Hospitalization  Obstetric History for maternity claims (GPAL Status)  Copy of MLC / FIR / in case of road traffic accidents (RTA)  AML documents (Proof of Identity with photo, Address proof) for above 1 lac claims
Note	Claim Documents Submitted- Check List:  Filled claim form duly signed  Copy of the claim intimation  Final Hospital Bill with detailed break-up  Hospital bill payment receipt  Detailed hospital discharge summary  Pharmacy / medical bills which supporting doctor prescription  Investigation / lab reports supporting the diagnosis.  Operation theatre notes for surgical cases  Invoice / sticker for the implants used in the treatment.  External Aids vendors supported by the proper prescription from Doctor.  Home Hospitalization treatment - Certificate from teating doctor specifying reasons for Home Hospitalization  Obstetric History for maternity claims (GPAL Status)  Copy of MLC / FIR / in case of road traffic accidents (RTA)  AML documents (Proof of Identity with photo, Address proof) for above 1 lac claims
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SECTION H

I hereby declare that the information furnished in this claim form is true & 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, 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	Y Place:	Signature of the Insured	

		FILLING CLAIM FORM – PART A (To be filled in by the insure	
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	I
a)	Policy No.	Enter the policy number	As allotted by the insurance company
b)	SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin Code
	S	ECTION B - DETAILS OF INSURANCE HISTORY	
a)	Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim /	Tick Yes or No
- \	Insurance?	Health Insurance	
p)	Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the insurance company
	Sum Insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
	Date	Enter the date of hospitalization	Use mm-yy 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
)	Company Name	Enter the full name of the insurance company	Name of the organization in full
_		ON C - DETAILS OF INSURED PERSON HOSPITALIZED	T =
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
)	Gender	Indicate Gender of the patient	Tick Male or Female
2)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify
)	Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
3)	Address	Enter the full postal address	Include Street, City and Pin Code
า)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALIZATION	
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
o)	Room category occupied	Indicate the room category occupied	Tick the right option
2)	Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d)	Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
9)	Date of admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh:mm format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
1)	Time	Enter time of discharge	Use hh:mm format
)	If Injury give cause	Indicate cause of 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
)	System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
_		SECTION E - DETAILS OF CLAIM	1 -1
a)	Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b)	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	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 Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
-,		SECTION F - DETAILS OF BILLS ENCLOSED	are right option
ndi	cate which bills are enclosed with the amounts in rupees	The state of the s	
. rull		G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
a)	PAN		As allotted by the Income Tax department
a) o)	Account Number	Enter the permanent account number  Enter the bank account number	As allotted by the bank
<u> </u>	Bank Name and Branch	Enter the bank account number  Enter the bank name along with the branch	Name of the Bank in full
c)		Enter the bank name along with the branch  Enter the name of the beneficiary the cheque/ DD should be	
d)	Cheque/ DD payable details	made out to	Name of the individual/ organization in full
	IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
e)	11 30 Gode		

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 preauthorization request form in lieu of PART A

(To be filled in block 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:	NAME MIDDLE NAME
b) IP Registration Number: C) Gender: Male Female	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y Y
f) Date of Admission: $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	d) Age: Years ▼ ▼ Months M M e) Date of birth: □ □ □ M M ▼ Y ▼ M h) Date of Discharge: □ □ M M ▼ Y Y i) Time: H H : M M  ermity i. Date of Delivery: □ □ M M ▼ Y Y ii. Gravida Status: □ □ □
j) Type of Admission: Emergency Planned Day Care Maternity k) If Male	ernity i. Date of Delivery: D D M M Y Y ii. Gravida Status: D D
l) Status at time of discharge: Discharge to home Discharge to another hos	pital Deceased D
DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
a) ICD 10 Codes Description	b) ICD 10 PCS Description
i. Primary Diagnosis:	i. Procedure 1:
ii. Additional Diagnosis:	ii. Procedure 2:
iii. Co-morbidities:	iii. Procedure 3:
iv. Co-morbidities:	iv. Details of Procedure:
c) Present ailment is a complication of PED? Yes No (If Yes, specify details)	
d) Pre-authorization obtained: Yes No e) Pre-authorization	Number:
f) If authorization by network hospital not obtained, give reason:	
g) 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: $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	(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	☐ Investigation reports
Original Pre-authorization request	CT/MR/USG/HPE investigation reports  Doctor's reference slip for investigation
Copy of the Pre-authorization approval letter Copy of photo ID card of patient verified by hospital	Doctor's reference slip for investigation  ECG  Pharmacy bills  MI C report & Police FIR
Hospital Discharge summary	Pharmacy bills
Operation Theatre notes Hospital main bill	MLC report & Police FIR Original death summary from hospital where applicable
Hospital break-up bill	Any other, please specify
DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL	L)
a) Address of the Hospital:	
City:	State:
Pin Code: b)Phone No.	
d) 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 INSURED	(PLEASE READ VERY CAREFULLY)
I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessa	belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right ry medical information / documents from any hospital / Medical Practitioner who has attended on the nerson
against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this or	
Date: D D M M Y Y Place:	Signature of the Insured:
Date: D D M M Y Y Place:  DECLARATION BY THE HOSPITAL	
DECLARATION BY THE HOSPITAL  We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge	Signature of the Insured:  (PLEASE READ VERY CAREFULLY)
DECLARATION BY THE HOSPITAL	Signature of the Insured:  (PLEASE READ VERY CAREFULLY)
DECLARATION BY THE HOSPITAL  We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge	Signature of the Insured:  (PLEASE READ VERY CAREFULLY)  e and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, orm B is fully filled up by us.
DECLARATION BY THE HOSPITAL  We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim F	Signature of the Insured:  (PLEASE READ VERY CAREFULLY)  e and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, orm B is fully filled up by us.

i)	DATA ELEMENT	DESCRIPTION SECTION A - DETAILS OF HOSPITAL	FORMAT
i)	· · · · · · · · · · · · · · · · · · ·		
i)	Name of Hospital	Enter the name of hospital	Name of hospital in full
)	Hospital ID	Enter ID number of hospital	As allocated by the TPA
	Type of Hospital	Indicate whether In network or non network nospital	Tick the right option
,	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
)	Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
	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
)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	S	ECTION B – DETAILS OF THE PATIENT ADMITTED	
)	Name of Patient	Enter the name of hospital	Name of hospital in full
)	IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
)	Gender	Indicate Gender of the patient	Tick Male or Female
)	Age	Enter age of the patient	Number of years and months
)	Date of Admission	Enter date of admission	Use dd-mm-yy format
	Time	Enter time of admission	Use hh:mm format
	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
	Time	Enter time of discharge	Use hh:mm format
	Type of Admission	Indicate type of admission of patient	Tick the right option
	If Maternity	,	<u> </u>
	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
	Gravida Status	Enter Gravida status if maternity	Use standard format
	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	<u> </u>	ON C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)	rick the right option
	ICD 10 Code	ON C - DETAILS OF AILMENT DIAGNOSED (FRIMART)	Т
		Enter the ICD 10 Code and description of the primary	
	Primary Diagnosis	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
)	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 Procedure	Enter the details of the procedure	Open text
)	Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
	Hospitalization due to injury	Indicate if hospitalization 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
		ION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
dica	ate which supporting documents are submitted	<u> </u>	
_		ON E – DETAILS IN CASE OF NON NETWORK HOSPITAL	
)	Address	Enter the full postal address	Include Street, City and Pin Code
	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
	Registration No.	Enter the registration number of patient	As allocated by the Hospital
_	PAN PAN	Enter the permanent account number	As allotted by the Income Tax department
_	Number of Inpatient Beds	Enter the number of inpatient beds	Digits
_	<u> </u>	Indicate facilities available in the hospital	
	Facilities available in the hospital		Tick the right option. If others, please spec
lac.	declaration corofilly and months date for date.	SECTION F - DECLARATION BY THE INSURED	
ead	declaration carefully and mention date (in dd:mm:yy form	nat), place (open text) and sign.  SECTION G - DECLARATION BY THE HOSPITAL	



## **POLICY DECLARATION FORM**

Date:
Name of the Hospital :
Address:
PATIENT NAME (BLOCK LETTERS): AGE/SEX: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 रीडूंबससमेंट/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