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.

Max Life Insurance Company Ltd.
90 A, Sector-18, Udyog Vihar, Gurgaon-122015, Haryana,
Phone Number- 0124-4219090- Extn- 9699, Toll Free- 18002005577
Email- claims.support@maxlifeinsurance.com

CLAIM FORM FOR HOSPITALIZATION REIMBURSEMENT BENEFIT FOR MEDICASH, MEDICASH PLUS AND HEALTHY FAMILY FLOATER

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 FIRSTNAME MIDDLENAME
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: d) Policy No.:
e) Sum Insured (Rs): f) Have you been hospitalized in the last four years since inception of the contract : Yes No Date: MM YY
Diagnosis: g) Previously covered by any other Mediclaim/Health insurance: Yes No
h) If Yes, Company Name:

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name: SURNAME FIRSTNAME MIDDLENAME
b) Gender: Male Female c) Age: YY MM 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 HOSPITALIZATION

a) Name of the Hospital where admitted:
b) Room Category occupied: Daycare Single Occupancy Twin Sharing 3 or more beds per room
c) Hospitalization due to: Illness Injury Maternity d) Date of Injury/ Date of 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:

SECTION E- 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.
v) Ambulance Charges Rs. vi) Others (code) Rs.
Total Rs.
vii) Pre-Hospitalization Period Days viii) Post -Hospitalization Period Days

b) Claim for Domiciliary Hospitalization: Yes No (if yes, please provide details in annexure)

c) Details of Lumpsum/ cash benefit claimed:

i) Hospital Daily Cash Rs. ii) Surgical Cash Rs.
iii) Critical Illness Benefit Rs. iv) Convalescence Rs.
v) Pre/Post hospitalization Lump sum benefit Rs. vi) Others Rs.
Total Rs.

Claim Documents Submitted- Check List:

- Duly filled and signed Claim Form
- Copy of intimation letter, if any
- Hospital Main Bill
- Hospital Break Up bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theater Notes
- ECG
- Doctor's Request for Investigation
- Doctor's Prescription
- Investigation Reports (Including CT, MRI/USG/HPE)
- Others

SECTION – F DETAILS OF BILLS ENCLOSED

Sr. No.	Bill No.	Date	Issued By	Towards	Amount (Rs)
1.		DD MM YY		Hospital main bill	
2.		DD MM YY		Pre - hospitalization bills - Nos.	
3.		DD MM YY		Post - hospitalization bills - Nos.	
4.		DD MM YY		Pharmacy bills	
5.		DD MM YY			
6.		DD MM YY			
7.		DD MM YY			
8.		DD MM YY			
9.		DD MM YY			
10.		DD MM YY			

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SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) Bank Name/ Branch:

d) Payable details: Cheque/ DD: e) IFSC Code:

SECTION H – DECLARATION BY THE INSURED

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 with respect to questions asked in relation to this claim, 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 Insured:

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
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
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-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 four years since inception of the contract?	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
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
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-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please
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 HOSPITALIZATION		
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) 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
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
I) 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
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 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		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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/ organization 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:yy format), place (open text) and sign.		

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CLAIM FORM FOR HOSPITALIZATION REIMBURSEMENT BENEFIT FOR MEDICASH, MEDICASH PLUS AND HEALTHY FAMILY FLOATER

CLAIM FORM – PART B

TO BE FILLED IN BY THE HOSPITAL

DETAILS OF HOSPITAL

a) Name of 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 SURNAME FIRST NAME MIDDLE NAME

Registration No. c) Gender Male Female d) Age Years Y Y Months M M e) Date of Birth D D M M Y Y

f) Date of Admission: D D M M Y Y 9) Time: H H : M M h) Date of Discharge D D M M Y Y i) Time: H H : M M

j) Type of Admission Emergency Planned Day Care k) If maternity i. Date of Delivery D D M M Y Y ii) Gravida Status

l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased

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-morbities:			iii. Procedure 3.		
iv) Co-morbities			iv). Procedure 4.		

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: 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 reasons

CLAIM DOCUMENTS SUBMITTED. CHECK LIST

- Claim Form duly signed
- Original Pre-authorized request
- Copy of the Pre-authorization approval letter
- Copy of photo ID card of patient verified by hospital
- Hospital Discharge summary
- 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 bills
- MLC report & Police FIR
- Original death summary from hospital where applicable
- Any other, please specify

DETAILS IN CASE OF NON-NETWORK (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of Hospital:

City: State:

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Phone Number- 0124-4219090- Extn- 9699, Toll Free- 18002005577
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Pin Code: ☐☐☐☐☐☐ b) Phone No. ☐☐☐☐☐☐☐☐☐☐ c) Registration 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 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 I insurance company, to seek necessary medical information I 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 I 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 Place: Signature of Insured:

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true & 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: D D M M Y Y Signature and seal of hospital authority

Place:

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

In-patient Treatment /Day Care Procedures

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- ☐ Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- ☐ Original payment Receipt of the hospital bill.
- ☐ First Consultation letter and subsequent Prescriptions.
- ☐ Original bills, original payment receipts and Reports for investigation.
- ☐ Original medicine bills and receipts with corresponding Prescriptions.
- ☐ Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts

Road Traffic Accident

In addition to the In-patient Treatment documents:

- ☐ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

In Non Medico legal cases

- ☐ Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- ☐ Copy of Post Mortem Report & Death Certificate (If conducted)

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Original Death Summary from the hospital.
- ☐ Copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

Pre and Post-Hospitalization expenses

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Medicine bills, original payment receipt with prescriptions.
- ☐ Original Investigations bills, original payment receipt with prescriptions and report.
- ☐ Original Consultation bills, original payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main claim.

Organ Donation/Transplantation

In addition to the documents of general hospitalization

- ☐ Organ Function test / blood test proving organ failure.
- ☐ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Bill with Original Payment Receipt.
- ☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization

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GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
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 treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) 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
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
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 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
b) 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
c) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) 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
SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
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.	Enter the registration number of patient	As allocated by the Hospital
d) 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 INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card

Please send the documents to any Max Life Branch Office or send the documents to below address.

PARAMOUNT HEALTH SERVICES (TPA) PVT. LTD,
R.O.: D-39, Okhla Industrial Area Phase-I, Near D.D Motors, New Delhi-110020.
For any assistance Call - PHS Toll free - 1800-290-3151. Tel. No.: 011-41637594/95/96. Fax: 011-41637592, 011-42890927/921.
E-Mail: phs.maxlife@paramounttpa.com

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