

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.O 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)		
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 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.			



CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED IN BY THE INSURED

(To be filled in BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability

SECTION A - DETAILS OF PRIMARY INSURED

a) Type of claim
Hospitalization Pre Hospitalization Post Hospitalization Health check-up OPD
b) Pre authorization obtained Yes No
c) Policy type Individual Group
d) Group/Company name
e) Policy No f) Sl. No/Certificate No
g) Company/TPA ID No. h) Name
I) Address
City State Pincode
Phone No Email ID.
j) PAN No
k) Monthly Income: Up to ₹ 20,000 ₹ 20,001 to ₹ 50,000 ₹ 50,001 to ₹ 1,00,000 ₹ 1,00,001 and above

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediciam/Health Insurance Yes No
b) Date of commencement of first insurance without break
c) If yes, company name
Policy No Sum Insured ₹
d) Have you been hospitalized in the last four years since inception of the contact? Yes No
Date Diagnosis
e) Previously covered by any other Mediciam/Health Insurance Yes No
f) If yes Company Name

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED

a) Name
b) Gender Male Female c) Age - years Months d) Date of birth
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

An ISO 9001:2015 Certified Company

SECTION D - DETAILS OF HOSPITALIZATION

- a) Name of Hospital where admitted _____
- b) Room Category occupied Day care 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 | d | m | m | y | y | y | y |
- e) Date of Admission | d | d | m | m | y | y | y | y | f) Time | H | H | M | M |
- g) Date of discharge | d | d | m | m | y | y | y | y | h) Time | H | H | M | M |
- i) If injury give cause: Self inflicted Road traffic accident Substance abuse /Alcohol consumption
- ii) 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 treatment expenses claimed
- i. Pre hospitalization expenses ₹ _____ ii. hospitalization expenses ₹ _____
- iii. Post hospitalization expenses ₹ _____ iv. Health check up cost ₹ _____
- v. Ambulance charges ₹ _____ vi. Others(code) ₹ _____
- TOTAL ₹ _____
- vii. Pre hospitalization period _____ days viii. Post hospitalization period _____ days
- b) Claim for Domiciliary Hospitalization 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 hospitalization Lump sum benefit ₹ _____/- vi Others ₹ _____/-
- TOTAL ₹ _____/-

SECTION F - DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date	Issued By	Towards	Amount ₹)
1		d d m m y y y y		Hospital main Bill	
2		d d m m y y y y		Pre hospitalization Bills _____Nos	
3		d d m m y y y y		Post hospitalization Bills _____Nos	
4		d d m m y y y y		Pharmacy Bills	
5		d d m m y y y y		Other expenses if any _____	
6		d d m m y y y y			
7		d d m m y y y y			
8		d d m m y y y y			
9		d d m m y y y y			
10		d d m m y y y y			

CLAIM DOCUMENTS SUBMITTED CHECK LIST

S.No	Documents	
1	<input type="checkbox"/> Claim form duly signed	7 <input type="checkbox"/> Pharmacy bill
2	<input type="checkbox"/> Copy of the claim intimation, if any	8 <input type="checkbox"/> Operation theatre notes
3	<input type="checkbox"/> Hospital main bill	9 <input type="checkbox"/> ECG
4	<input type="checkbox"/> Hospital break up bill	10 <input type="checkbox"/> Doctor's request for investigation
5	<input type="checkbox"/> Hospital bill payment receipt	11 <input type="checkbox"/> Investigation reports (including CT/MRI/USG/HPE)
6	<input type="checkbox"/> Hospital discharge summary	12 <input type="checkbox"/> Doctor's prescriptions
		13 <input type="checkbox"/> Others

As per policy terms & conditions, the Company reserves its right to have the Insured examined by a Doctor appointed by it for verification of diagnosis.



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 Health 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 हूँ 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 हूँ 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 रीड्यूबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूंकि 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