PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED (IRDA License No. 006)

[formerly known as PARAMOUNT HEALTH SERVICES (TPA) PVT.LTD]

Plot no.A-442, Road No-28,M.I.D.C Industrial Area, Wagale Estate, Ram Nagar, Vitthal Rukmani Mandir, Thane (W), Mumbai, Pin Code – 400 604

CLAIM ACKNOWLEDGMENT SHEET

Name of Insurer :		**PHS ID :**	
Insured Name :		**Employee No :**	
Patient Name :		**Mobile No :**	
Policy No :		**Phone (STD) :**	
Name of Corporate:			
Type of Claim (To be ticked) :	Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	**E-Mail ID of primary insured :**	

CLAIM DOCUMENT CHECK LIST

Sr. No	Description	Document Status(Y/N)	Remarks
1	IRDA Claim Form duly signed by the Insured & Hospital		
	Part-A: Duly signed by the insured with Claimed amount ,Mobile number & Email ID along with PHS ID		
	Part-B: Duly signed and stamped by hospital		
	Declaration form duly signed & stamped by the hospital in case treatment taken is under PPN/GIPSA hospitals.		
2	In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same.		
3	Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the Account Holder Printed on the Cheque Leaf.		
4	ID Proof of Employee / Primary Insured- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID) . If Claim is above 1 lakh- PAN is mandatory with address Proof		
5	ID Proof of Patient- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID)		
6	Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care Treatment) / Death Summary (in Case of Death Claim)		
6.a	Copy of the Legal heir certificate (if the claim is for the death of the principle insured)		
6.b	Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)		
7	Policy Copy **(if individual policy)**		
8	64VB Compliance Certificate **(If individual policy)**		
9	Original Final Hospital bill with cost wise breakup of each Item		
10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)		
10.a	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip as received from the Vendor		
11	Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL		
12	Original bills, original Payment Receipts and investigation / Laboratory Reports		
13	Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions.		
14	Original copy of First Consultation letter and subsequent Prescriptions.		
15	Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not falls in GIPSA/PPN)		
16	**OTHER DOCUMENTS**		
16.a	Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)		
16.b	Original Sonography Report in case of Maternity Claim		
16.c	Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract Claim		
16.d	Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA)		
16.e	A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases)		
16.f	In case of claims where the insured has submitted documents to another insurance co./TPA, he needs to submit attested Photocopies of all the documents along with detailed claim settlement letter from the TPA and any unpaid bills and receipt for the same in originals.		

Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital

Claim Submitted by:		**Mobile No.**	
Date of Claim Submission:	DD/MM/YYYY HH:MM	**PHS Executive Name:**	
Claim Submitted at:	PHS - (Location) / Help Desk	**Signature:**	

Important Points to Remember:-

1. Please mark either √ or × against respective check box
2. Date of File Received will be considered as next working day for Claim Files picked up at Help Desk
3. Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital
4. The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our document recovery team will contact you on receipt of your claim documents by us
5. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

SBI General INSURANCE

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

GROUP HEALTH INSURANCE POLICY

Claim Form

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

Claim No.

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Insured — SURNAME MIDDLENAME FIRSTNAME
2. Name of the Claimant — SURNAME MIDDLENAME FIRSTNAME
3. Relationship with Insured — Date of Birth (DD MM YYYY)
4. Gender — ☐ Male ☐ Female
5. Contact Details
   - House No. — Block
   - Building — Locality
   - Street
   - City — District
   - State — Pincode
   - Phone No. — Mobile
   - Email ID

B. DETAILS OF POLICY

1. Policy No. — Health Card No.
2. Period of insurance — From (DD MM YYYY) To (DD MM YYYY)
3. Employee No. — Group / Company Name

C. DETAILS OF OTHER POLICY

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

   If 'Yes', please enclose photocopies of all previous policies

   - Name of Insurer
   - Policy No. — Name of TPA
   - Period of insurance — From (DD MM YYYY) To (DD MM YYYY) — Sum Insured

D. DETAILS OF PREVIOUS HEALTH CLAIM

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

   If 'Yes', please provide details

   - Previous Claim No.
   - Diagnosis
   - Date of admission (DD MM YYYY) — Date of Discharge (DD MM YYYY)
   - Paid ☐ Yes ☐ No — Amount settled
   - Repudiated ☐ Yes ☐ No

   If Yes, reason for Repudiation _____

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E. DETAILS OF ILLNESS/ACCIDENT

1. Nature of disease/illness/injury
2. Signs and symptoms of illness
3. Diagnosis of illness
4. When did you first notice signs and symptoms of the illness? (D D M M Y Y Y Y)
   When did you first consult your doctor for the illness? (D D M M Y Y Y Y)
5. When was the illness first diagnosed/detected? (D D M M Y Y Y Y)
6. Have you ever had the similar illness in past? ☐ Yes ☐ No
   If 'Yes', provide details,
7. Any other illness in the past?
8. Name of the Doctor consulted first for this illness
9. Contact Details of the Doctor
   Phone No. Mobile
   E-mail Id
10. Date & Time of Admission (D D M M Y Y Y Y) (:) A.M. / P.M.
11. Date & Time of Discharge (D D M M Y Y Y Y) (:) A.M. / P.M.
12. Type of Admission ☐ Emergency ☐ Planned ☐ Daycare
13. Type of Claim ☐ Hospitalization ☐ Pre Hospitalization ☐ Post Hospitalization
14. Type of Hospital ☐ Network ☐ Non-Network
15. Type of Treatment ☐ Allopathic ☐ Ayurvedic ☐ Homeopathic ☐ Unani ☐ Other

F. DETAILS OF HOSPITAL

1. Name of the Hospital
2. Address of the Hospital
   House No. Block
   Building Locality
   Street
   City District
   State Pincode
3. Name of treating Doctor
4. Qualification of treating Doctor
   Treating Doctors Registration No.
5. Contact Details
   Phone No. Mobile
   E-mail ID

Place

Date (D D M M Y Y Y Y)

Stamp and Signature of the treating Doctor

G. DETAILS OF CURRENT CLAIM BILLS

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

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

H. ENCLOSURE CHECKLIST

- ☐ Claim Form duly filled & signed
- ☐ Discharge Card / Certificate
- ☐ Hospitalization Bills
- ☐ Medicine Bills
- ☐ Investigation Bills
- ☐ Valid Photo Identity Card
- ☐ Medical Certificate
- ☐ FIR/ MLC copy
- ☐ Investigation Reports
- ☐ Any other documents
- ☐ Doctor's Prescription
- ☐ Any other documents, please specify _____

I. DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

Pan Card No. | Account No.

Bank and Branch Name

Cheque/ DD payable details

Indian Financial System Code (IFSC)

J. DETAILS OF OTHER INFORMATION

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

   If 'Yes', specify _____

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

Place

Date: D D M M Y Y Y Y

Signature of Claimant

Name of Insured/Claimant

K. DETAILS TO BE FILLED BY HOSPITAL

1. Name of the patient

IP Registration No.

	ICD 10 codes	Description
a. Primary Diagnosis		
b. Additional Diagnosis		
c. Co-morbidities		
d. Co-morbidities		
e. Procedure 1		
f. Procedure 2		
g. Procedure 3		
h. Details of Procedure		

2. Pre-authorization Obtained ☐ Yes ☐ No

If Yes, Pre-authorization No.

If authorization is not obtained by network hospital please give reason

Is Hospitalization due to injury? ☐ Yes ☐ No

If Yes, ☐ Self inflicted ☐ RTA ☐ Any Other

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

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

Medico legal ☐ Yes ☐ No

Reported to police ☐ Yes ☐ No

FIR No.

If not reported to Police give reason

We hereby declare that information furnished in this 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.

Place

Date: D D M M Y Y Y Y

Stamp and Signature of the Hospital Authority