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.

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

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

MAGMA HDI General Insurance Company Ltd.

SECTION A - DETAILS OF PRIMARY INSURED: (To be filled in block letters)

a) Policy No: b) SI. No/ Certificate No:

c) Company/ TPA ID No:

d) Name:

e) Address:

City: State:

Pin Code: Landline (With STD Code):

Mobile No:

[PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE SENT TO THIS EMAIL ID.]

Email ID:

Alternate Email ID:

SECTION B - DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No b) If yes, Policy Type: ☐ Individual ☐ Group

Company Name: Policy No.:

c) Date of commencement of first Insurance without break: d) Sum Insured (Rs.):

Have you been hospitalised in the last four years since inception of the contract? ☐ Yes ☐ No

Diagnosis:

f) Previously covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No

g) If yes, Company Name:

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED:

a) Name:

b) Gender: ☐ Male ☐ Female c) Age: Years Y Y Months M M d) Date of Birth: D D M M Y Y Y Y

e) Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

f) Address (if different from above):

City: State:

Pin Code: Phone No:

Email ID:

g) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify)

h) Name of Employer/ Firm's Name:

i) Address of the Employer/Firm:

SECTION D - DETAILS OF HOSPITALISATION:

a) Name & Address of Hospital where Admitted:

City: State:

Pin Code: Landmark:

b) Room Category occupied: ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

☐ Other (Please specify)

c) Hospitalisation 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 f) Time: H H : M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M

i) In case of maternity, I) Date of Delivery: D D M M Y Y II) Gravida Status:

j) 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

k) System of Medicine:

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

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SECTION E - DETAILS OF CLAIM:

a) Details of the other treatment expenses claimed

S.N.	Cover Name	Amount (in Rs)	S.N.	Cover Name	Amount (in Rs)
	Pre Hospitalization Expenses			Green channel benefit claim against Health wearable device	
	Post Hospitalization Expenses			Compassionate Visit in case of CI	
	Ambulance Cover			Vaccination for new born	
	Organ Donor Expenses			Out-patient Cover	
	Green channel benefit claim against Non payable expenses			Air Ambulance	

• For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

b) Details of Lump sum / cash benefit claimed

S.N.	Cover Name	Claimed	S.N.	Cover Name	Claimed
	Hospital Cash	☐ Yes ☐ No		Companion Benefit	☐ Yes ☐ No
	Loss of income benefit	☐ Yes ☐ No		Convalescence Benefit	☐ Yes ☐ No
	Enhanced Daily cash benefit	☐ Yes ☐ No		Benefit under Critical Illness optional Cover, if opted	☐ Yes ☐ No
	Home treatment additional daily Cash benefit	☐ Yes ☐ No		Benefit under Personal Accident optional Cover, if opted	☐ Yes ☐ No

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

Check List of Claim Documents to be submitted (In original)* - Please (✓) tick relevant box

(For Hospital Cash benefit, photocopies of claim documents are acceptable)

☐ Claim Form duly filled and signed	☐ Copy of the Claim Intimation, if any	☐ Hospital Bill Payment receipt
☐ Hospital Main Bill	☐ Hospital Break-up Bill	☐ Doctor's request for investigation
☐ Hospital Discharge Summary	☐ Pharmacy Bill	☐ Operation Theatre Notes
☐ Investigation Reports (Including CT / MRI / USG / HPE / ECG)		☐ Test report and prescription relating to first consultation for the Illness
☐ Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital		☐ FIR / MLC in case of accident injury and English translation of the same if it is in any other language
☐ KYC document (Address proof, ID proof only for claims exceeding ₹1 Lakh)		☐ Original Death Summary (Wherever applicable)
☐ Cancelled cheque leaf of the bank account held in the name of the primary insured (Mandatory)		☐ Any Other

*Please retain copy of complete set of claim documents for your records

SECTION F - DETAILS OF BILLS ENCLOSED:

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

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

Receipt No.	Date	Amount (Rs)	Please (✓) Tick Relevant Box	
			☐ Advance Receipt	☐ Final Receipt
			☐ Advance Receipt	☐ Final Receipt
			☐ Advance Receipt	☐ Final Receipt
			☐ Advance Receipt	☐ Final Receipt

Note: Please attach separate sheet if necessary

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

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MAGMA HDI General Insurance Company Ltd.

IF THE CLAIM IS FOR ACCIDENTAL INJURIES, PLEASE PROVIDE DETAILS OF DATE, TIME AND CIRCUMSTANCES OF ACCIDENT EVENT AND OTHER DETAILS AS RELEVANT:

Date: D D M M Y Y Y Y Time: H H : M M

Circumstances of Accident event and other details: _____

SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT:

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) IFSC Code:

e) Cheque/ DD Payable Details:

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, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA / insurance company to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended the person for 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 pre/post hospitalization claim and for additional covers, if any.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured:

Please send this duly filled and signed claim form to our TPA at below address:

Family Health Plan Insurance TPA Limited

Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

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 organisation
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) i. Company Name	Enter the full name of the insurance company	Name of the organisation in full
b) ii. Policy No.	Enter the policy number	As allotted by the insurance company
c) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
d) Sum Insured	Enter the total sum insured as per the policy	In rupees
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
f) Date	Enter the date of hospitalisation	Use mm-yy format
g) Diagnosis	Enter the diagnosis details	Open Text
h) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
i) Company Name	Enter the full name of the insurance company	Name of the organisation in full

MAGMA HDI
General Insurance Company Ltd.

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

DATA ELEMENT	DESCRIPTION	FORMAT
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 specify
f) Address	Enter the full postal address	Include Street, City and Pin Code
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
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
i) Address of the Employer	Complete address of the employer of the Insured	Include Street, City and Pin Code
SECTION D - DETAILS OF HOSPITALISATION FOR CLAIM BEING FILED		
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-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) In case of maternity		
I. Date of delivery	Enter date of delivery	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida Status	Use standard format
j) If Injury give cause	Indicate cause of injury	Tick the right option
i. If Medico Legal	Indicate whether injury is Medico Legal	Tick Yes or No
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
k) 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 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) 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.		

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

The issuance of this Form is not to be taken as an admission of liability
Please include the original pre-authorisation request form in lieu of PART A

MAGMA HDI
General Insurance Company Ltd.

SECTION A - DETAILS OF HOSPITAL (To be filled in block letters)

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: ☐ Network ☐ Non-Network (For office use only)

d) Name of the treating doctor:

e) Qualification:

f) Registration No. with State Code: g) Phone No.:

SECTION B - DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number: c) Gender: ☐ Male ☐ Female

d) Age: ☐☐ Years ☐☐ Months e) Date of birth: D D M M Y Y Y Y

f) Date of Admission: D D M M Y Y Y Y g) Time: H H : M M

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

j) Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity: i. Date of Delivery: D D M M Y Y Y Y ii. Gravida Status:

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

m) Total amount claimed:

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)		ICD 10 Codes	Description	a)		ICD 10 PCS Codes	Description
1	Primary Diagnosis:			1	Procedure 1:		
2	Additional Diagnosis:			2	Procedure 2:		
3	Co-morbidities:			3	Procedure 3:		
4	Co-morbidities:			4	Details of Procedure:		

c) Whether pre-authorisation obtained: ☐ Yes ☐ No d) If Yes, pre-authorisation Number:

e) If authorisation by network hospital not obtained, give reason: _____

_____

f) Hospitalisation due to injury: ☐ Yes ☐ No If Yes, give cause:

i. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐ Other

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 the police: ☐ Yes ☐ No

v. FIR No.: vi. If not reported to the police, give reason: _____

_____

g) When did the patient start suffering of the complaint: _____

Date of first consultation: D D M M Y Y Y Y

h) Please give previous medical history of the patient: _____

I) Is the patient suffering from any of the following diseases? If "Yes" Please mention the duration below.

		Yes / No	Duration in year & months
1	High or low blood pressure, chest pain, or any other cardiac disorder		
2	Tuberculosis, asthma, bronchitis or any other lung / respiratory disorder		
3	Ulcer (stomach / duodenal), liver or gall bladder disorder or any other digestive tract disorder		
4	Kidney failure, stone in kidney or urinary tract, prostate disorder or any other kidney / urinary tract disorder		
5	Stroke, epilepsy (fits), paralysis or any other nervous system (brain, spinal cord, etc) disorder		

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

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MAGMA HDI
General Insurance Company Ltd.

		Yes / No	Duration in year & months
6	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder		
7	Tumor (swelling)-benign or malignant, any external ulcer / growth / cyst / mass anywhere in the body		
8	Arthritis, spondylosis or any other disorder of the muscle / bone / joint		
9	Diseases of the ear / nose / throat / teeth / eye (please mention dioptres in case of refractory error)		
10	HIV / AIDS or sexually transmitted diseases or any immune system disorder		
11	Anaemia, leukaemia, lymphoma or any other blood / lymphatic system disorder		
12	Psychiatric / mental illnesses or sleep disorder		
13	Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder		
14	Any other illness or injury not mentioned above (other than common cold)		

g) Is the ailment a complication / sequel of a pre-existing disease or condition? ☐ Yes ☐ No

If Yes, please give details: _____

h) History of alcoholism ☐ Yes ☐ No If yes: No of years: ☐☐ Quantity consumed per day ☐☐☐

I) History of smoking / tobacco chewing: ☐ Yes ☐ No If Yes: No of years: ☐☐ Units consumed per day ☐☐☐

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

☐ Claim Form duly signed	☐ Investigation reports
☐ Original pre-authorisation request	☐ CT/MR/USG/HPE investigation reports
☐ Copy of the pre-authorisation approval letter	☐ Doctor's reference slip for investigation
☐ Copy of photo ID card of patient verified by hospital	☐ ECG
☐ Hospital discharge summary	☐ Pharmacy bills
☐ Operation theatre notes	☐ MLC report & Police FIR
☐ Hospital main bill	☐ Original death summary from hospital where applicable
☐ Hospital break-up bill	☐ Other, please specify

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

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. Round the clock Doctor / Nurses: ☐ Yes ☐ No

iv. Maintains daily record of patients: ☐ Yes ☐ No v. Others:

SECTION F - DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

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, suppressed or concealed 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:

Please send this duly filled and signed claim form to our TPA at below address:
Family Health Plan Insurance TPA Limited
Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

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

Please include the original pre-authorisation request form in lieu of PART A

MAGMA HDI General Insurance Company Ltd.

Authorisation Letter (Mandatory)

Date: D D M M Y Y Y Y

From:

To:
The Manager / Medical Superintendent, Medical Records

Dear Sir

Reg: Authorisation Letter.

Name of the Patient: _____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____ (Third admission) in _____Hospital

I consent and authorise M/s Magma HDI General Insurance Co. Limited and their Authorised Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and / or meet / obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalisation dated ..... to .....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient

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 Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
I) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity	Tick the right option	Tick the right option
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy 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 amount claimed	Indicate the total amount claimed	In rupees (Do not enter paise values)

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

DATA ELEMENT	DESCRIPTION	FORMAT
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) Whether pre-authorisation obtained	Indicate whether pre-authorisation obtained	Tick Yes or No
d) Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtainingpre-authorisation number	Open text
f) Hospitalization 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 the police, give reason	Enter reason for not reporting to the police	Open text
g) Complaints / Symptoms	Indicate the date when the symptom / complaint	Use dd-mm-yy format
h) Previous medical history	Enter the medical history	Open text
i) Specific diseases	State Yes or No	Duration should be in years and months
j) Complication of pre-existing diseases	Indicate whether present ailment is a complication that existed prior to policy inception	Open text
k) Alcoholism	Indicate Yes or No. If 'yes' state quantity consumed	Open text
l) Smoking of tobacco	Indicate Yes or No. If 'yes' state units consumed	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. with State Code	Enter the registration number of the doctor along with the state code	As allocated 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 at the hospital	Indicate facilities available at the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read the declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		