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 : Employee No : Insured Name: Patient Name : Mobile No : Phone (STD) : Policy No : Name of Corporate: Type of Claim (To Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit E-Mail ID of be ticked) : primary insured: CLAIM DOCUMENT CHECK LIST Document Sr. No Description Remarks Status(Y/N) 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 1 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. In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating 2 reason for the same. Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the Account Holder Printed on the Cheque 3 Leaf. ID Proof of Employee / Primary Insured- Any of one (Passport, Voter ID, Driving License, Or any Government Approved 4 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 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) 64VB Compliance Certificate (If individual policy) 8 Original Final Hospital bill with cost wise breakup of each Item 9 Original Payment Receipt of Main Hospital bill (both Deposit / Refund) 10 Receipt Of Payments made at the Hospital by Credit Card: Please attach the Xerox Copy of the Credit Card Payment Slip 10.a Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL 11 Original bills, original Payment Receipts and investigation / Laboratory Reports 12 Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions. 13 Original copy of First Consultation letter and subsequent Prescriptions. 14 Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not 15 falls in GIPSA/PPN) 16 OTHER DOCUMENTS Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim) 16.a Original Sonography Report in case of Maternity Claim 16.b Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract 16.c Claim Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case 16.d of Road Traffic Accident (RTA) 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.e In case of claims where the insured has submitted documents to another insurance co/TPA, 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: Date of Claim PHS Executive DD/MM/YYYY HH:MM Submission: Name: Signature: Claim Submitted at: PHS - (Location) / Help Desk 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
- 7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

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IFFCO-TOKIO DE NEHAL INSURANCE MUSKUrate Kaho	CLAIM FORM - PART B IFFCO TOKIO GENERAL INSUFANCE COMPANY LIMITED CIN: U74899DL2000PLC107621 TO BE FILLED IN BY THE HOSPITAL The issue of this Form is not to be taken as an admission of lia Please include the original preauthorization request form in lieu of I	ability (To be filled in block letters)
	A. 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:		
e) Qualification:	f) Registration No. with State Code:	g) Phone No.
	B. DETAILS OF THE PATIENT ADMITTED:	
a) Name of the Patient: b) IP Registration Number:	c) Gender: Male Female d) Age: Years	Y Y months M M e) Date of birth:
f) Date of Admission: D D M M	Y Y g) Time: H H : M M h) Date of Dischar	
j) Type of Admission: Emergency Planned	Day Care Maternity k) If Maternity i. Date of	
I) Status at time of discharge: Discharge to home	Discharge to another hospital Deceased	m) Total Claimed Amount: Rs.
i, otatio at timo of districting.	C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)	ing rotal diametration.
a) ICD 10 Codes	Description b)	ICD 10 Codes 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 Proced	dure:
c) Present ailment is a complication of PED?	Yes No (If Yes, specity details)	
d) Pre-authorization obtained:	Yes No e) Pre-authorization Number:	
f) If authorization by network hospital not obtained, give reason	n:	
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. Te	st Conducted to establish this: Yes No (If Yes, attach reports) iii. If	f Medico legal: Yes No iv. Reported to Police: Yes No
v. FIR no.	vi. If not reported to police give reason:	
	D. CLAIM DOCUMENTS SUBMITTED - CHECK LIST	
Claim Form duly signed	Operation Theatre notes	Doctor's reference slip for investigation
Original Pre-authorization request	Hospital main bill	ECG
Copy of the Pre-authorization approval le Copy of photo ID card of patient verified		Pharmacy bills MLC report & Police FIR
Hospital Discharge summary	CT/MR/USG/HPE investigation reports	Original death summary from hospital where applicable
Any other, please specify	O THE DOCUMENT E INVESTIGATION TOPOTO	Original death summary from hospital where applicable
	NAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CAS)	SE OF NON-NETWORK HOSPITAL)
a) Address of the Hospital:	AL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CAS)	E OF NON-INE I WORK HOSPITAL)
City:	State:	Pin Code:
b) Phone No.	c) Registration No.:	Date of Registration: D D M M Y Y
Expiry date of Registration D D M M	Y Name of the Registering Authority:	
d) PAN:	e) Number of Inpatient beds f) Facilities available in th	ne hospital: i. OT: Yes No ii. ICU: Yes No
iii. Others:		
	F. DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAF	REFULLY)
We hereby declare that the information furnished in this Claim right to claim under this claim shall be forfeited. The signature	n Form is true & correct to the best of our knowledge and belief. If we have made a s of the insured is taken on this form after Claim Form B is fully filled up by us.	any false or untrue statement, suppression or concealment of any meterial fact, our
Hospital have required infrastructure to fulfill the hospital defir o Has at least 10 inpatient beds, in those towns having a population of less		
o Has fully qualified nursing staff under its employment round the clock		
 Has fully qualified doctor(s) in charge round the clock Has a fully equipped operation theatre of its own where surgical procedure 	es are carried out.	
o Maintains daily Medical records of patients and will make these accessible		
Date: D D M M Y Y	Place:	
5440. D D WI WI I T		Insured / Claimant: Signature and Seal of the Hospital Authority: