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.

UNITED INDIA INSURANCE COMPANY LIMITED

Reg. & Head Office: 24, Whites Road, Chennai - 14.

BRANCH / DIVISIONAL OFFICE.....

SUPER TOP UP MEDICARE CLAIM FORM

Claim No. Policy No.

Issue of this form does not amount to admission of any liability under the claim on the part of the insurers.

Please give the following information correctly and completely to enable the Company to process your claim promptly.

1	a) Name of the Insured (Name in full) b) Address c) Occupation	
2	Details of Insured Person: a) Name of the person in respect of whom the claim is made. b) Relationship to the Insured c) Present completed age d) Occupation e) Residential address.	
3	**Details of Hospitalisation**: a) Name of the Insured person (in respect of whom claim is made) b) Present completed age c) Nature of Disease / Illness contracted or injury sustained d) Date of injury sustained or disease/ illness first detected e) Date of Intimation to TPA f) Name and address of the Hospital / Nursing Home g) Date of Admission h) Date of Discharge	a) b) c) d) e) f) g) h)

5 *Details of previous hospitalisations in respect of the Insured Person/s during this policy period*

Name of the Insured person	Health Insurance Policy No./Reimbursement Benefit Scheme	Illness suffered	Date of admission	Date of discharge	Amount claimed (only Inpatient hospitalisation exp) not to include pre and post-hosp. Exp.	Amount reimbursed/ reimbursable by TPA / Reimbursement Provider**	Name of the TPA / Re.Provider

** Supporting documents in original or attested photocopies to be furnished

6	Total Expenses incurred for claimed hospitalisation	
	SCHEDULE OF HOSPITALISATION EXPENSES INCURRED	
Details of expenses claimed for Hospitalisation (to be supported by Bills, Receipts, Cash Memos along with discharge summary)		Amount Claimed Rs
a)	Hospitalisation: a) Room Board, Nursing Expenses for days @Rs. per day b) I.C.U charges for days @ Rs. per day	
b)	Non-Surgical & Surgical: a) Surgeon & Anaesthetist fees b) Medical Practitioners, Consultants and specialists fees for consultations No of visits c) Nursing expenses	
c)	a) Anaesthetic, Blood, Oxygen, Operation Theatre Charges, Surgical appliances. b) Diagnostic materials and X-Ray.,etc., c) Dialysis, Chemotherapy, Radiotherapy, Cost of peacemaker, Artificial Limbs & Cost of organs and similar expenses d) Medicines and Drugs i) Supplied by Hospital ii) Purchased from Chemists	
e)	Total Expenses	
f)	Expenses reimbursed/reimbursable under other Health Insurance Policies/Reimbursement Scheme towards all hospitalisations during the policy period plus any previous claims made under this Policy or Threshold Level whichever is higher	
g)	Claim under this Policy (e-f)	

Note : If the original bills are submitted to Primary Health Insurer/Reimbursement Provider, attested photo-copies may be furnished.

I hereby declare that I have incurred on the treatment of Disease/Illness /Accident referred above, the expenses as per the details given by me. In support of this claim, I enclose all relevant bills vouchers and other documents.
I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited and I shall rendered myself liable to any legal action.

Place:
Date: Signature of Insured Person