

| 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  |  |                                       |         |
| <b>CLAIM ACKNOWLEDGMENT SHEET</b>   |  |                                       |         |
| <b>Name of Insurer :</b>  |  | <b>PHS ID :</b>                       |         |
| <b>Insured Name :</b>   |  | <b>Employee No :</b>                  |         |
| <b>Patient Name :</b>   |  | <b>Mobile No :</b>                    |         |
| <b>Policy No :</b>  |  | <b>Phone (STD) :</b>                  |         |
| <b>Name of Corporate:</b>   |  |                                       |         |
| <b>Type of Claim (To be ticked) :</b>   | Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit   | <b>E-Mail ID of primary insured :</b> |         |
| <b>CLAIM DOCUMENT CHECK LIST</b>  |  |                                       |         |
| 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 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 )   |                                       |         |
| 16  | <b>OTHER DOCUMENTS</b>   |                                       |         |
| 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. |                                       |         |
| <b>Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital</b>  |  |                                       |         |
| <b>Claim Submitted by:</b>  |  | <b>Mobile No.</b>                     |         |
| <b>Date of Claim Submission:</b>  | DD/MM/YYYY HH:MM   | <b>PHS Executive Name:</b>            |         |
| <b>Claim Submitted at:</b>  | PHS - (Location) / Help Desk   | <b>Signature:</b>                     |         |
| <b>Important Points to Remember:-</b>   |  |                                       |         |
| 1. Please mark either <b>✓</b> or <b>✗</b> 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 <a href="http://www.paramounttpa.com">www.paramounttpa.com</a> 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.  |  |                                       |         |