	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), Mun	nbai, Pin Code – 400	604
	CLAIM ACKNOWLEDGMENT SHEET		
Name of Insurer :		PHS ID :	
Insured Name :		Employee No :	
Patient Name :		Mobile No :	
Policy No :		Phone (STD) :	
	Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	E-Mail ID of	
be ticked):	CLAIM DOCUMENT CHECK LIST	primary insured :	
Sr. No	Description	Document Status(Y/N)	Remarks
	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.		
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	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		
16.d	Claim Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case		
10.0	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		
16.e	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		
	d will be considered as next working day for Claim Files picked up at Help Desk		
3. Claim Need to be Su	bmitted within 7 Working Days from Date of Discharge from Hospital ruments is indicative. In case of any other document requirement as specified by the Insurance Company, our document r	recovery team will c	ontact you on receipt of
your claim documents 5. Please visit us at ww	by us w.paramounttpa.com to check Online Claim Status or download Paramount Mobile App		
	o keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitte	ed will not returned	unless approved & agreed
	ocuments 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



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SECTION A - DETAILS	OF	PR	RW.	AR۱		1SL	JRE	D:	(To	be	fill	ed	in	blc	ock	k le	tter	s)																	
a) Policy No:			Τ]	b) :	SI. N	No/	Ce	rtifi	cate	N	o:												
c) Company/ TPA ID No:		Ē	T]																				
d) Name:			T												İ	Τ																			
e) Address:			T													Ī																\square			
City:			T														Stat	e:														\square			
Pin Code:												Lo	anc	dlin	e (Wit	h ST	TD (Cod	le):															
Mobile No:]																																
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SECTION B - DETAIL	s c	ÞF I	NS	UR	AN	CE	HI	STC	DRY	:																									
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Company Name:		Γ	Τ												Γ	Ī					Pol	icy	No).:				1				\square			
c) Date of commencement	of fi	rst I	Insu	rano	ce v	vitho	out	brec	ık:	-		-			-	_		-		d)	Sur	n Ir	ารบ	red	(Rs	5.):									=
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Diagnosis:		Γ	T			/-										Τ	Τ		F																
f) Previously covered by any	L	l or l	Moc	licla	im	L / Н/				nce	. [V	es			lo		1										I						
g) If yes, Company Name			T		,						,. [10	55			T		1				_					1	1					-1	
g) il yes, Company Name	·																																		
SECTION C - DETAIL	S C)F I	INS	SUR	ED	PE	RS	NС	HC	DSI	PIT/	ALIS	Sei	D:																					
a) Name:																																			
b) Gender:		Μ	\ale	[Fei	mal	е	c)	Ag	je:	Yea	rs	Y	Y	7	Ν	lon	ths	Μ	М	c	d) C	Date	e of	Bir	th:	D	D	Μ	M	Y	Y	Y	Y
e) Relationship to Primary I	nsur	ed:		Se	lf [Spo	ouse	e [Ch	ild			Fa	ithei	r [Mot	ther			Oth	ner	(Ple	ease	e Sj	pec	ify)						
f) Address (if different from	n al	oov	′e):																																
City:			Τ												Sto	ate:																			
Pin Code:		Γ	T										Pł	non	e١	No:			Γ													\square			
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g) Occupation:		Se	ervic	:e		Self	En	nplo	yed		1	lom	nen	nak	er		Stu	Jdei	nt [Reti	red			Dth	er (Ple	ase	sp	ecif	y)				
h) Name of Employer/ Firm's Name:																																			
i) Address of the		Γ	Γ													Т	Τ																		
Employer/Firm:		-	4								-					_		-	-			-									LI				
SECTION D - DETAIL	.s c) DF	НС	SP	TA	LIS	ATI	ON	:																										
a) Name & Address of		_											_		_	Т	1		<u> </u>									1							
Hospital where Admitted																			_																
City:																	Sto	ate:																	
Pin Code:								La	ndr	nar	k:																								
b) Room Category occupied	:] D	ay a	care	, [3	Sing	jle c	occu	pa	ncy			Twir	n s	har	ing		3	or	mo	re k	bed	s p	er r	100	n								
		0	Othe	r (P	leas	se s	pec	ify)																											
c) Hospitalisation due to:		 In	njury	/	1	Illne	ess		M	ate	rnit	у																							
d) Date of Injury / Date D	isec	ıse	first	t de	tect	ed	/ D	ate	of [Deli	ver	y:			D	М	M	Y	Y	Y	(
e) Date of Admission:	D	D	Μ	Μ	Y	Y	f)	Tim	ne:	Н	Н	· \		N	0	a) D	ate	of [Disc	har	 ae:	D	D	M	M	Y	Y	r	h) T	ime	e: -	-11-	- - - - - -	M	M
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j) If injury give cause:	., -	7	elf-i					Ro	ad	Tra	ffic	Acc					-		anc	۵ ۵	hue	a /	Alc	oh		ìon	sur	nnti	on						
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k) System of Medicine:			\bot																									1				ட			



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 (\checkmark) 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 investigation done outside hospital	purchased outside the hospital and	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 p	proof only for claims exceeding ₹1 Lakh)	Original Death Summary (Wherever applicable)
Cancelled cheque leaf of the bank primary insured (Mandatory)	account held in the name of the	Any Other

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

SECTION F - DETAILS OF BILLS ENCLOSED:

JLCH		ILS OF BILLS LINCLY	J 3LD.		
Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	
2.				Pre-hospitalisation Bills:	los
3.				Post-hospitalisation Bills: N	los
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

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



IF THE CLAIM IS FOR ACCIDENTAL INJURIES, AND OTHER DETAILS AS RELEVANT:	PLEASE PROVIDE DETAILS OF DATE, TIME AND	O CIRCUMSTANCES OF ACCIDENT EVENT
Date: DDMMYY	Y Y Time: H H : M M	
Circumstances of Accident		
SECTION G - DETAILS OF PRIMARY IN	SURED's BANK ACCOUNT:	
PLEASE PROVIDE YOUR BANK DETAILS: (PLEA INSURED WITHOUT FAIL)	se attach cancelled cheque leaf of ba	NK ACCOUNT IN THE NAME OF PRIMARY
a) PAN:	b) Account Number:	
c) Bank Name and Branch:		
d) IFSC Code:		
e) Cheque/ DD Payable Details:		
SECTION H - DECLARATION BY THE IN	ISURED:	
forfeited. I also consent & authorise TPA / insurance who has attended the person for whom this claim is	e company to seek necessary medical information /	his claim, my right to claim reimbursement shall be documents from any hospital / Medical Practitioner bills / receipts for the purpose of this claim & that I overs, if any.
Place:		Signature of the Insured:
GUIDANCE FOR FILLING CLAIM FORM	d Floor, Road No. 2, Banjara Hills, Hyderabad, T - PART A (To be filled in by the insured)	
DATA ELEMENT		FORMAT
a) Policy No.	SECTION A - DETAILS OF PRIMARY INSURED Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate	As allotted by the organisation
c) Company TPA ID No.	number of social health insurance scheme Enter the TPA ID No.	License number as allotted by IRDA and printed
		in TPA documents.
d) Name e) Address	Enter the full name of the policyholder Enter the full postal address	Surname, First name, Middle name Include Street, City and Pin Code
· ·	SECTION B - DETAILS OF INSURANCE HISTOR	
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		, , ,
d) Sum Insured Have you been Hospitalised in the last four years since inception of the contract?	insurance	Use dd-mm-yy format
Have you been Hospitalised in the last four years	insurance Enter the total sum insured as per the policy	Use dd-mm-yy format
Have you been Hospitalised in the last four years since inception of the contract?	insurance Enter the total sum insured as per the policy Indicate whether hospitalised in the last four years	Use dd-mm-yy format In rupees Tick Yes or No
Have you been Hospitalised in the last four years since inception of the contract? f) Date	insurance Enter the total sum insured as per the policy Indicate whether hospitalised in the last four years Enter the date of hospitalisation	Use dd-mm-yy format In rupees Tick Yes or No Use mm-yy format

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



SECTION C - DETAILS OF INSURED PERSON HOSPIT LIZED I Name Enter the full name of the patient Surname, First name, Middle name I Gender Indicate gender of the patient Tack Male or Female J Age Enter oge of the patient Number of years and months I Date of Birth Enter Date of Birth of patient Use damm-yy format I Relationship to primary Insured Indicate relationship of patient Use damm-yy format Address Enter the full postal oddress Inducts Street, City and Pin Code Phone No. Enter the patient on potent Tack the right option. If others, pleose specify Occupation Indicate occupation of potent Tack the right option. If others, pleose specify I Address of the Employer Complete address of the employer of the Insured Include Street, City and Pin Code I Name of hospital where admitted Enter the relevand to the organital Name of hospital full Name of hospital full I Roar of hospital where admitted Enter the relevand tote Use damm-yy format Indicate researe of hospital full I Roar of hospital where admitted Enter date of admission Use damm-yy format Indicate researe	DATA ELEMENT	DESCRIPTION	FORMAT
a) Name Enter the full nome of the patient Sungame, First name, Middle name b) Gender Indicate gander of the patient Tick Mole of Fernale c) Age Enter age of the patient Number of years and months c) Date of Birth Enter age of the patient Use dd-nm-xy format c) Balandaniju to primary Insured Indicate relationship of patient Use dd-nm-xy format c) Address Enter the hip boat address Include Street, City and Pin Code Phone No. Enter the hip boat address Include Street, City and Pin Code c) Occupation Indicate accupation of patient Tick the right address c) Occupation Indicate accupation of patient Complete address of the employer of the Insured c) Name of hospital where admitted Enter the nome of hospital Name of hospital in full c) Name of hospital where admitted Indicate the room category accupied Tick the right aption c) Name of hospital where admitted Indicate trasson of hospital statiant full Use dd-mm-xy format c) Name of hospital where admitted Indicate reason of hospital statiant Use dd-mm-xy format c) Date of ingr/v. Enter the role of admission Use dd-mm-xy format c) Date of delivery Enter date of admission Use dd-mm-xy format c) Date of delivery Enter date of admission <t< td=""><td></td><td></td><td></td></t<>			
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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
The issuance of this form is not to be taken as an damission of hability

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SEC	TION C - DETAILS	s Of	F AIL	MEI	NTI	DIA	G٨	IOSI	ED (PR	MA	RY)	\$,																			
a)		ICD) 10 (Cod	es			Des	scrip	tior	E.	Ň		a))						I	CD	10	PCS	6 Co	odes	5	[Desc	cript	ion		
1	Primary Diagnosis:								۲	<u>S</u> ,		/		1	F	Proce	edu	re 1:															
2	Additional Diagnosis:						1	S	<u>`</u>	/				2	F	Proce	edu	re 2:															
3	Co-morbidities:					Ś).	_						3	F	Proce	edu	re 3:															
4	Co-morbidities:		\square		4		/							4	[Deta	ils c	of Pro	oce	dure	:												
c) Wh	ether pre-authorisa	tion o	obtax	ied:		1	ſes		No		d)	lf Y	′es,	pre	e-a	utha	oris	atio	n N	lum	be	r: [
e) If c	uthorisation by netw	vol C	iospi	itell	not	obta	ine	d, gi	ve re	eas	on:																1						
		4	\angle																														
f) Hos	spitalization e to i	njury	<i>r</i> :	Y	es		Nc	b If	Yes,	, gi	ve co	ause	e:																				
		i. 🗌	Se	lf-in	flict	ed		R	oad	Tro	affic	Acc	ide	nt		S	ubs	stan	ce	abu	se	/ al	coho	ol c	วทรเ	Jmp	otior	ı [Oth	er		
(PAI	ii. If	f Injur	y du	e to	subs	stan	ice al	ouse	/ a	lcoh	ol co	ons	υm	ptic	on, te	est (conc	luc	ted t	io e	estab	lish	this	: [Y	és		No)			
	$\mathbf{\tilde{\mathbf{v}}}$	(If Y	les, a	ttacl	h re	port	s)																										
		iii. I	If Med	dico	Leg	ıal:		Yes] N	0	_	iv.	Rej	por	ted	to	the _l	pol	ice:			Yes		٨	0							
		v. F	IR No).:									vi.	lf r	not	rep	orte	ed to	o th	ne p	olio	ce, g	give	rea	son	:							
																																	—
g) Wł	nen did the patient s			-				ſ		_						_																	
			te of f						D	D	M	1 Y	Y			Y																	
	ase give previous m							-		0.1	6 113 /																						—
I) Is fr	ne patient suffering f	rom	any c	of th	ie to	llow	ring	dise	ases	S¢ I	t "Ye	s" P	lea	se r				ne d	ura	itior	n be	elow	′.					_					_
1	Hish as low blood as				·										Ye	es / I	No							Du	uratio	on ir	n yeo	ar &	mor	nths			
1	High or low blood pre disorder	essure	e, ches	si po	ain, c	or an	y 01	ner c	araic	ac																							
2	Tuberculosis, asthma, disorder	bron	ıchitis	or a	ny o	ther	lunę	g / re	spira	itory	/																						
3	Ulcer (stomach / duo any other digestive tra				gall	blad	der	disor	der d	or																							
4	Kidney failure, stone i disorder or any other								e																								
5	Stroke, epilepsy (fits), (brain, spinal cord, et			r an	y oth	ner n	ervo	ous sy	vstem	ı																							

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



			Yes / No	Duration in year & months
6	Diabetes, Impaired glucose tolerance (Pre-diabetes),			
7	Thyroid/Pituitary Disorder or any other endocrine disorder Tumor (swelling)-benign or malignant, any external ulcer /			
8	growth / cyst / mass anywhere in the body 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			(nh
12	Psychiatric / mental illnesses or sleep disorder			citle /
13	Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder			GED
14	HIV / AIDS or sexually transmitted diseases or any immune system disorder Anaemia, leukaemia, lymphoma or any other blood / lymphatic system disorder Psychiatric / mental illnesses or sleep disorder Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder Any other illness or injury not mentioned above (other than common cold) the ailment a complication / sequel of a pre-existing disea , please give details: story of alcoholism Yes No If yes: No of yea story of smoking / tobacco chewing: Yes No CTION D - CLAIM DOCUMENTS SUBMITTED - CH Claim Form duly signed Original pre-authorisation request Copy of the pre-authorisation approve letter Copy of photo ID card of patient veiled by hospital Hospital discharge summary Operation theatre notes Hospital major bill Hospital break bill THON ELADITIONAL DETAILS IN CASE OF NON- dress withe hospital:			THIS
g) Is t	the ailment a complication / sequel of a pre-existing dise	ase or cor	ndition?	No No
If Yes	, please give details:	/	<u></u>)' /
h) Hi	story of alcoholism 🗌 Yes 🗌 No 🛛 If yes: No of yea	ars:		tity consumed per day
I) Hi	story of smoking / tobacco chewing: 🌅 Yes 📃 No	If Yes	of years:	: Units consumed per day
SEC	CTION D - CLAIM DOCUMENTS SUBMITTED - CH	K L K	Г	
	Claim Form duly signed			estigation reports
H	Original pre-authorisation request			/MR/USG/HPE investigation reports
H	Copy of the pre-authorisation approve letter			ctor's reference slip for investigation
H	Copy of photo ID card of patient served by bospital			G
HH	Hospital discharge supragne			armacy hills
┝╞╡	Operation theatra notes			C report & Police FIR
┝╞╡				iginal death summary from hospital where applicable
H	Hospital break G bill			her, please specify
SEC	dres whe hospital:	NETWO	rk hosi	PITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)
City:			State	s.
Pinco				
	gistration No. with State Code:			d) Hospital PAN:
f) Fac	cilities available in the hospital: i. OT: Yes No iv. Maintains daily record	ii. ICU: of patient	Yes is: Yes Ye	Noiii. Round the clock Doctor / Nurses:YesN esNov. Others:
SEC	CTION F - DECLARATION BY THE HOSPITAL (PLEA	SE READ) VERY (
We h	ereby declare that the information furnished in this Claim e any false or untrue statement, suppressed or concealed	Form is t	rue & cor	rrect to the best of our knowledge and belief. If we have
			,	
Date				
Place				Signature and Seal of the Hospital Authority:
Ple	ase send this duly filled and signed claim form to our TPA	at below	address:	
Fa	mily 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



Authorisation Letter (Mandatory)

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

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 ADMITTE	ED			
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			
I) 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)			

Date: DDMMYYYY

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



ATA ELEMENT	DESCRIPTION	FORMAT
:	section C - details of ailment diagnosed (pr	IMARY)
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 / alcoho consumption, test conducted to establish		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
n) Previous medical history	Enter the medical history	Open text
i) Specific diseases	State Yes or No	Duration should be in years and months
i) 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
ç	SECTION D - CLAIM DOCUMENTS SUBMITTED-CHE	CK LIST
Indicate which supporting documents are sub	mitted.	
SI	CTION E - DETAILS IN CASE OF NON-NETWORK H	OSPITAL
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	