Sr. No.	Particulars	Type of Document	Check Box
1	**Claim Need to be Submitted within 7 Working Days from Date of Discharge**		
2	Duly filled and signed Claim Form by the insured / employee with Claimed Amount, Mobile Number & Email ID along with Copy of PHS ID.	Claim Form In Original .Copy Of The ID	
3	Photocopy of ID card with Address Proof for Claims More than 1 Lac	Copy	
4	**Original Cancelled Cheque of Employee/Proposer with the name of the Account Holder Printed on the Cheque Leaf.**	Original	
5	Nature of the Claim Document - Fresh Claim/ Pre Post Claim/ Deficiency Retrieval Document / Critical Illness/OPD/Daily Cash Benefit	Indicate The Nature Of The Claim	
6	Original Detailed Discharge Summary / Day care summary from the hospital in case of Day Care Treatment/Death Summary in Case of Death Claim	Original	
	a) Copy of the Legal heir certificate, if the claim is for the death of the principle insured.	Copy	
	b) Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)	Copy	
7	Original Final Hospital bill with breakup of each Item.	Original	
8	Original Payment Receipt of Main Hospital bill (both Deposit & Refund)	Original	
	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	Copy	
9	Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/Mesh/IOL	Original	
10	Original bills, original payment receipts and investigation/Laboratory Reports.	Original	
11	Original medicine bills with Patient Name and date of purchase with corresponding Prescriptions.	Original	
12	First Consultation letter and subsequent Prescriptions.	Original	
13	In case of No intimation/Delay submission of files letter from the insured required stating reason for the same.		
14	**OTHERS**		
a	Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)	Original	
b	One Sonography Report in case of Maternity Claim	Original	
c	A Scan' Report along with IOL sticker and tax paid invoice in case of Cataract Claim	Original	
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)	Copy	
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)	Original	
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.	Settlement Letter In Original. Unpaid Bills And Receipt In Original	

Important Notes:

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. 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.

4. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App.

5. 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.

6. Corrections in any documents are not allowed.

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Comp/June/Int/3765

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

HDFC Life
Sar utha ke jiyo!

(To be filled in block letters)

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F | SECTION G

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No./Certificate No:
c) Company/TPA ID No:
d) Name : SURNAME FIRST NAME MIDDLE NAME
e) Address :
City: State:
Pin Code: Phone No: Email ID:

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim/Health insurance: Yes No b) Date of commencement of first insurance without break: DD MM YY
c) If yes, company name: Policy No.
Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: MM YY
Diagnosis : e) Previously covered by any other Mediclaim/Health Insurance: Yes No
f) If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME
b) Gender: Male Female c) Age: years YY MM d) Date of Birth: DD MM YY
e) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please Specify)
f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)
g) Address (if different from above):
City: State:
Pin Code: Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:
b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room
c) Hospitalization due to: Injury Illness Maternity d) Date of injury/Date Disease first detected/Date of Delivery DD MM YY
e) Date of Addmission: DD MM YY f) Time: HH : MM g) Date of Discharge: DD MM YY h) Time: HH : MM
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abude / Alcohol Comsumption i) If Medico legal: Yes No
ii) Reported to police: Yes No iii) MLC Report & Police FIR attached Yes No j) System of Medicine

DETAILS OF CLAIM

a) Details of the treatment expenses claimed:

i. Pre-Hospitalization Expenses:	Rs.	ii. Hospitalization Expenses:	Rs.
iii. Post-Hospitalization Expenses:	Rs.	iv. Health-Check up Cost:	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code):	Rs.
		Total	Rs.
vii. Pre-Hospitalization period:	Days	viii. Post-Hospitalization period:	Days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash	Rs.	ii. Surgical Cash:	Rs.
iii. Critical illness Benefit:	Rs.	iv. Convalescene:	Rs.
v. Pre/Post Hospitlaization		vi. Others:	Rs.
Lump sum benefit	Rs.	**Total**	Rs.

Claim Documents Submitted - Check List:

- Claim Form Duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (including CT/MRI/USG/HPE)
- Doctor's Prescriptions
- Others
- Attested photocopy of cancelled cheque / passbook copy*

DETAILS OF BILLS ENCLOSED:

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

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:
c) Bank Name and Branch:
d) Cheque/DD Payable details: e) IFSC Code:

(IMPORTANT:PLEASE TURN OVER)

Note: As per IRDA circular dated February 13, 2014, all payouts to policyholders are to be made via the electronic mode [NEFT] only.

DECLARATION BY THE INSURED:

SECTION H

I hereby declare that the information furnished in this claim is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfieted. I also consent & authorise TPA/Insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that i have included all the bills / receipts for the purpose of this claim & that will not be making any suplementary claim except the pre/post-hospitalization claim, if any

Date: D D M M Y Y Place _____ Signature of the Insured

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) Sl. No./Certificate No.	Enter the social insurance number of the certificate number of social health insurance scheme	As allotted by the organization
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 Medicliam / Health Insurance	Tick Yes or No
b) Date of Commencement of first insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	User mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
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) Occupation	Indicate occupation of patient	Tick the right option, if others, please specify
g) Address	Enter the full postal address	Include street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where Insured	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	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) If injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury in medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) 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 Hospitalization	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 bank name along with the branch	Name of the bank in full
d) Cheque/DD payable details	Enter the name of beneficiary the cheque/DD should be made out to	Name of the individual/organization in full
e) 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.		