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.

EDELWEISS GROUP HEALTH INSURANCE - CLAIM FORM A

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Instructions:

1. This form should be filled in by the member
2. Issuance of this form does not imply acceptance of liability
3. Please fill all the details in BLOCK LETTERS
4. All fields in this form are mandatory
5. If there is any other information to be provided, please write the same in a separate sheet, sign the sheet and attach it to this Claim Form

SECTION A – SOME DETAILS ABOUT YOU

a) Policy No.: b) Certificate No.:

c) TPA ID No.:

d) Name of the Member:

e) ID proof type: PAN Passport Driving License Elector's Photo Identity Card

f) Address: Landmark:

City: State: Pin Code:

Phone No.: Email ID:

g) Name of Insured / Policyholder: Employee No.: Branch Location:

SECTION B – SHARE YOUR PAST/OTHER INSURANCE INFORMATION

a) Are you currently covered by any other Mediclaim / Health Insurance: Yes No

b) Date of beginning of the First Insurance without break: D D M M Y Y Y Y

c) If Yes, Name of Insurer: Policy No.: Sum Insured (INR):

d) Have you been Hospitalized in the last four years since the start of such policy? Yes No Date: D D M M Y Y Y Y

Diagnosis:

e) Have you been previously covered by any other Mediclaim / Health Insurance: Yes No

f) If yes, Name of Insurer:

SECTION C – A BIT ABOUT THE PERSON HOSPITALIZED

a) Name:

b) ID proof type: PAN Passport Driving License Elector's Photo Identity Card

c) Gender: Male Female Third Gender d) Age: Years Months e) Date of Birth: D D M M Y Y Y Y

f) Relationship with Primary Member: Self Spouse Child Father Mother Other (Please specify)

g) Occupation: Service Self-employed Homemaker Student Retired Other (Please specify)

h) Address (if different from above):

City: State: Pin Code:

i) Phone No.: j) Email ID:

SECTION D – TELL US MORE ABOUT THE HOSPITALIZATION

a) Name of Hospital, wherein Admitted:

Address:

Landmark:

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 on which Disease was First Detected / Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y Y Y Time: H H : M M

f) Date of Discharge: D D M M Y Y Y Y Time: H H : M M

g) If injury, give cause: Self Inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption

h) If Medico-legal: (i)Yes No (ii) Reported to Police: Yes No (iii) MLC Report & Police FIR attached: Yes No

i) System of Medicine:

SECTION E – WHAT DO WE NEED FOR YOUR CLAIM?

a) Details of the treatment expenses claimed for

(i) Pre-Hospitalization cost: ₹ _____ (ii) Hospitalization cost: ₹ _____

(iii) Post-Hospitalization cost: ₹ _____ (iv) Health check-up cost: ₹ _____

(v) Ambulance charges: ₹ _____ (vi) OPD: ₹ _____

Total: ₹ _____

(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: ₹ _____ (ii) Surgical cash: ₹ _____

(iii) Critical Illness benefit: ₹ _____ (iv) Convalescence: ₹ _____

(v) Pre / Post Hospitalization lump sum benefit: ₹ _____ (vi) Others: ₹ _____

Total: ₹ _____

The documents we'll need

- ☐ Duly signed Claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Hospital release in short
- ☐ Pharmacy bill
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's prescriptions
- ☐ Hospital bill payment receipt
- ☐ Operation theatre notes

SECTION F – DETAILS OF BILLS ENCLOSED

Sr.No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		(DD/MM/YYYY)		Hospital Main Bill	
2		(DD/MM/YYYY)		Pre-Hospitalization Bills: ___ nos.	
3		(DD/MM/YYYY)		Post-Hospitalization Bills: ___nos.	
4		(DD/MM/YYYY)		Pharmacy Bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

SECTION G - IN CASE IT'S AN ACCIDENT (Tick the right option)

a) Death ☐ b) Permanent Partial Disability ☐ c) Permanent Total Disability ☐ d) Temporary Total Disability ☐

SECTION H - TELL US MORE ABOUT THE ACCIDENT

a) Date and time of accident: D D M M Y Y Y Y and H H : M M b) Place of accident: _____

c) Cause of accident: _____ d) Was there any Hospitalization due to an Accident?: _____

SECTION I - THE MEMBER'S OR NOMINEE'S BANK ACCOUNT DETAILS

a) PAN (if amount is or exceeds INR 1lakh): ☐☐☐☐☐☐☐☐☐☐

b) Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: _____

d) Cheque / DD payable details ☐☐☐☐☐☐☐ e) IFSC: ☐☐☐☐☐☐☐☐☐☐☐

SECTION J - DETAILS OF OUT - PATIENT COVER

a) Treatment start date: D D M M Y Y Y Y b) Treatment end date: D D M M Y Y Y Y

c) Name and contact details of treating doctor: _____

d) Name and address of clinic / hospital: _____

e) Nature of illness / disease: _____

f) Consultation fees: _____ g) Pharmacy / Investigations etc.: _____

SECTION K – DECLARATION BY THE MEMBER / NONIMEE

(PLEASE READ VERY CAREFULLY)

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / Insurer, to seek necessary medical information / documents from any hospital / medical practitioner who has treated the person for whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any other claim except the pre / post Hospitalization claim, if any.

Date: D D M M Y Y Y Y

Place: _____

Signature of the Member

SOME TIPS TO FILL THE CLAIM FORM – PART A

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - SOME DETAILS ABOUT YOU		
a) Policy No.	Enter the Policy number	As given by the Insurance Company
b) Certificate No.	Enter the certificate number written on your certificate of insurance	As appears on the certificate
c) TPA ID No.	Enter the TPA ID number	License number as given by IRDAI and printed in TPA documents
d) Name of the member	Enter the full name of the member	Surname, First name, Middle name
e) ID Proof	Select the correct option	Tick on appropriate option
f) Address	Enter the full postal address	Include street, city and pin code
g) Name of Insured / Policyholder	Enter the full name of the Policyholder	Surname, First name, Middle name
Employee No.	Enter Employee No.	
Branch Location	Enter Branch Location	
SECTION B – SHARE YOUR PAST/OTHER INSURANCE INFORMATION		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of beginning of the First Insurance without break	Enter the date of starting of First Insurance	Use dd-mm-yyyy 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 given 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 the start of such policy	Tell us if Hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use dd-mm-yyyy format
Diagnosis	Enter the Diagnosis Details	Open Text
e) Have you been previously covered by any other Mediclaim / Health Insurance	Tell is if earlier 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 - A BIT ABOUT THE PERSON HOSPITALIZED		
a) Name	Enter the full name of the Patient	Surname, First name, Middle name
b) ID Proof	Select the correct option	Tick on appropriate option
c) Gender	Indicate gender of the Hospitalized person	Tick on appropriate option
d) Age	Enter age of the Patient	Number of years and months
e) Date of Birth	Enter date of birth of Patient	Use dd-mm-yyyy format
f) Relationship with Primary Member	Indicate relationship of Hospitalized person with the Primary Member	Tick the right option. If others, please mention.
g) Occupation	Indicate occupation of Hospitalized person	Tick the right option. If others, please mention.
h) Address	Enter the full Postal Address	Include street, city and pin code
i) Phone No	Enter the phone number of Hospitalized person	Include STD code with telephone number
j) E-mail ID	Enter the e-mail id of Hospitalized person	Complete e-mail address
SECTION D – TELL US MORE ABOUT THE HOSPITALIZATION		
a) Name of Hospital, wherein Admitted	Enter the name of Hospital	Name of Hospital in full
b) Room category occupied	Indicate the room category taken	Tick the right box
c) Hospitalization due to	Indicate reason of Hospitalization	Tick the right box
d) Date of Injury / Date on which disease was First Detected / Date of Delivery	Enter the relevant date	Use dd-mm-yyyy format
e) Date of Admission	Enter date of Admission	Use dd-mm-yyyy format
Time	Enter time of Admission	Use hh:mm format
f) Date of Discharge	Enter date of Discharge	Use dd-mm-yyyy format
Time	Enter time of Discharge	Use hh:mm format

SOME TIPS TO FILL THECLAIM FORM – PART A

g) If injury, give cause	Indicate cause of injury	Tick the right option
h) If Medico-legal	Indicate whether injury is medico-legal or not	Tick Yes or No
Reported to police	Indicate whether police report was filed or not	Tick Yes or No
MLC report & police FIR attached	Indicate whether MLC report and police FIR was attached or not	Tick Yes or No
i) System of medicine	Enter the system of medicine followed in treating the Hospitalized person	Open text
SECTION E - WHAT DO WE NEED FOR YOUR CLAIM?		
a) Details of treatment expenses	Enter the amount claimed as treatment costs	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 the bills which are enclosed, alongwith the amounts in rupees		
SECTION G - IN CASE IT'S AN ACCIDENT (Tick the right option)		
a) Death	Indicate whether claim is for death	Tick the right option
b) Permanent Partial Disability	Indicate whether claim is for PPD	Tick the right option
c) Permanent Total Disability	Indicate whether claim is for PTD	Tick the right option
d) Temporary Total Disability	Indicate whether claim is for TTD	Tick the right option
SECTION H – TELL US MORE ABOUT THE ACCIDENT		
a) Date and time of Accident	Indicate the date and time of Accident	Use dd-mm-yyyy format & HH:MM
b) Place of Accident	Indicate the place of Accident	Mention the place of Accident
c) Cause of Accident	Indicate the cause of Accident	Mention the cause of Accident
d) Was there any Hospitalization due to an Accident?	Indicate whether Hospitalization was undertaken or not	Mention whether Hospitalization was undertaken or not
SECTION I – THE MEMBER'S OR NOMINEE'S BANK ACCOUNT DETAILS		
a) PAN (if amount is or exceeds INR 1lakh)	Enter the permanent account number (if applicable)	As given by the Income Tax department
b) Account No.	Enter the bank account number	As given by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the bank in full
d) Cheque / DD payable details	Enter the name of the beneficiary to whom the payment should be made out to	Name of the person / organization in full
e) IFSC	Enter the IFSC of the bank branch	IFSC of the bank branch in full
SECTION J - DETAILS OF OUT - PATIENT COVER		
a) Treatment start date	Enter treatment start date	Use dd-mm-yyyy
b) Treatment end date	Enter treatment end date	Use dd-mm-yyyy
c) Name and contact details of treating doctor	Enter name and contact details of treating doctor	Name and contact details of treating doctor
d) Name and address of clinic / hospital	Enter Name and address of clinic / hospital	Name and address of clinic / hospital
e) Nature of illness / disease	Enter name of the disease	Name of disease / ICD code
f) Consultation fees	Enter the amount claimed as treatment costs	In rupees (Do not enter paise values)
g) Pharmacy / Investigation fees	Enter the amount claimed as treatment costs	In rupees (Do not enter paise values)
SECTION K – DECLARATION BY THE MEMBER / NONIMEE		
Read declaration carefully and mention date (in dd:mm:yyyy format), place (open text) and sign.		

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EDELWEISS GROUP HEALTH INSURANCE - CLAIM FORM B

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Instructions:
1. This form should be filled in by the hospital
2. Issuance of this form does not imply acceptance of liability
3. Fill all details in BLOCK LETTERS
4. Please add the original pre-authorization request form with Part A

SECTION A - ABOUT THE HOSPITAL AND DOCTOR

a) Name of Hospital: _____

b) Hospital ID: _____ c) Type of Hospital: ☐ Network ☐ Non-network (If non-network, fill Section E)

d) Name of attending doctor: _____ e) Qualification: _____

f) Registration No. with state code: _____ g) Phone No.: ☐☐☐☐☐☐☐☐☐☐

SECTION B - SOME DETAILS ABOUT THE PATIENT

a) Name of the patient: _____

b) Name of the member: _____ c) Department: _____

d) Employee No.: _____ e) Name of the Insured / Policyholder: _____ f) Branch: _____

g) Date of Admission: D D M M Y Y Y Y h) Time of Admission: H H M M

i) Date of Discharge: D D M M Y Y Y Y j) Time of Discharge: H H M M

k) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity

l) If Maternity, (i) Date of Delivery: D D M M Y Y Y Y (ii) Gravida Status: _____ _____ _____

m) Status at time of Discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

n) Total claimed amount (in ₹): _____

o) Age Y Y M M p) Gender: ☐ Male ☐ Female ☐ Third gender q) Date of Birth: D D M M Y Y Y Y

SECTION C - WHAT WAS THE PRIMARY AILMENT BEING TREATED?

a)	ICD 10 Codes	Description
(i) Primary Diagnosis:		
(ii) Additional Diagnosis:		
(iii) Co-morbidities:		
(iv) Co-morbidities:		

b)	ICD 10 PCS	Description
(i) Procedure 1:		
(ii) Procedure 2:		
(iii) Procedure 3:		
(iv) Details of procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization No.: _____

e) If the network hospital has not agreed, please state the reason: _____

f) 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, test conducted to prove this: ☐ Yes ☐ No (If Yes, attach reports)

(iii) If medico-legal: ☐ Yes ☐ No

(iv) Reported to Police: ☐ Yes ☐ No

(v) If reported, FIR No.: _____

(vi) If not reported, please state the reason: _____

SECTION D - HAVE ALL THE DOCUMENTS YOU NEED?

☐ Signed Claim Form
☐ Original pre-authorization request
☐ Investigation reports
☐ CT / MR / USG / HPE investigation reports

- ☐ Copy of the pre-authorization approval letter
- ☐ Copy of photo ID card of patient, verified by hospital
- ☐ Discharge summary
- ☐ Operation theatre notes
- ☐ Main hospital bill
- ☐ Hospital bill break-up
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & police FIR
- ☐ Original death summary from hospital, where needed
- ☐ Any other, please specify

SECTION E - NON-NETWORK HOSPITAL? PLEASE HELP US WITH SOME DETAILS.

a) Address of Hospital: _____

_____

Landmark: _____ City: _____ State: _____ Pin Code: | | | | | | |

b) Phone No.: | | | | | | | | | | | c) Registration no. with state code: _____

d) PAN of hospital: _____ e) Number of inpatient beds: _____

f) Facilities given in the hospital: (i) OT: ☐ Yes ☐ No (ii) ICU: ☐ Yes ☐ No

(iii) Medical Store: ☐ Yes ☐ No (iv) Pathology: ☐ Yes ☐ No (v) Radiology: ☐ Yes ☐ No (vi) Other: _____

SECTION F - DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information given in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement and / or suppressed or hidden any material fact, our right to claim shall stand forfeited.

Date: | D | D | M | M | Y | Y | Y | Y |

Place: _____

Signature and stamp of authorized signatory

SOME TIPS ON HOW TO FILL CLAIM FORM– PART B

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - ABOUT THE HOSPITAL AND DOCTOR		
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	Write if in network or non-network hospital	Tick the right option
d) Name of attending doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Educational qualifications in short
f) Registration No. with state code	Enter the registration number of the doctor along with the state code	As given by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - SOME DETAILS ABOUT THE PATIENT		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) Name of the member	Enter the name of member	Name of member in full
c) Department	Enter name of department	Name of department in full
d) Employee no.	Enter Employee No.	
e) Name of the Insured/ Policyholder	Enter the full name of the Policyholder	Surname, First name, Middle name
f) Branch	Enter Branch Location	
g) Date of Admission	Enter date of admission	Use dd-mm-yyyy format
h) Time of Admission	Enter time of admission	Use hh:mm format
i) Date of Discharge	Enter date of release	Use dd-mm-yyyy format
j) Time of Discharge	Enter time of release	Use hh:mm format
k) Type of Admission	Indicate type of admission of patient	Tick the right option
l) If Maternity		
Date of Delivery	Enter date of delivery, in case of maternity	Use dd-mm-yyyy format
Gravida Status	Enter gravida status if maternity	Use standard format
m) Status at time of discharge	Indicate status of patient at time of release	Tick the right option
n) Total claimed amount (in ₹)	Indicate the total claimed amount	In rupees (Do not enter paise values)
o) Age	Enter age of the Patient	Number of years and months
p) Gender: Male, Female, Third gender	Indicate gender of the Hospitalized person	Tick on appropriate option
q) Date of Birth	Enter date of birth of Patient	Use dd-mm-yyyy format
SECTION C - WHAT WAS THE PRIMARY AILMENT BEING TREATED?		
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) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization No.	Enter pre-authorization number	As allotted by TPA
e) If the network hospital has not agreed, please state the reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury or not	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse / alcohol consumption, test conducted to establish this	Indicate if test is done or not	Tick Yes or No
medico-legal	Indicate whether injury is medico legal or not	Tick Yes or No
Reported to police	Indicate whether police report was filed or not	Tick Yes or No
If reported, FIR No.	Enter first information report number	As issued by police authorities
If not reported, please state the reason	Enter reason for not reporting to police	Open Text
SECTION D - HAVE ALL THE DOCUMENTS YOU NEED?		
Indicate which supporting documents are submitted.		
SECTION E - NON-NETWORK HOSPITAL? PLEASE HELP US WITH SOME DETAILS		
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 given by the Medical Council of India
d) PAN of hospital	Enter the permanent account number	As given by the Income Tax Department
e) Number of inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities given in the hospital	Facilities in the hospital	Tick the right option. If others, please mention
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yyyy format), place (open text) and sign and stamp.		

Edelweiss General Insurance Company Limited, Corporate Office: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai-400070, Registered Office: Edelweiss House, Off CST Road, Kalina, Mumbai-400 098, IRDAI Regn. No.: 159, CIN: U66000MH2016PLC273758, Reach us on: 1800 12000, Email: support@edelweissinsurance.com, Website: www.edelweissinsurance.com, Issuing/Corporate Office: +91 22 2286 4400, Grievance Redressal Officer: +91 22 4931 4422, Dedicated Toll-Free Number for Grievance: 1800 120 216216. Trade logo displayed above belongs to Edelweiss Financial Services Limited and is used by Edelweiss General Insurance Company Limited under license.