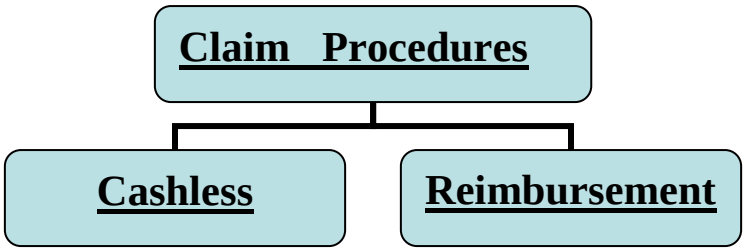

HOW TO OBTAIN CASHLESS FACILITY Procedure:

Important:

We request all members who want to available cashless benefit to kindly call up our Helpline / Call Centre (66620808/1800-22-66-55) and confirm their policy service status & hospital network status

Intimation must be given to Paramount TPA before 48hrs from Date of admission (or as per your policy) to call center on phone or by mail to claim.intimation@paramounttpa.com as per the format & you will received an intimation no.

1. Insured has to arrange for the Admission Request Note to be sent across from respective network hospital to Paramount.
2. Admission request note is available on admission counter of network hospitals.
3. The admission request note is to be filled in by the treating Doctor with his signature & stamped by the Hospital.
4. It is mandatory for insured to mention the PHS ID on the request for proper identification / verification & further processing. In case of corporate employees the group name & employee code too should be specified.
5. It is mandatory for Insured to thoroughly check the request note (to ensure that all required details are furnished & holds true to the best of their knowledge) & duly signing it as a confirmation

6. Above mentioned points are very important for registration of claim & further processing
7. Send the Admission request note to PHS 24 x 7 Help Desk (022 – 66620808)
8. Fax: 022 28259743 / 543 / 784 / 489. Also Request is available here for download.
9. On receipt of the completely filled request letter, claim will be registered & a unique claim number (FIR / CCN) will be generated. All correspondence will be against specific FIR for that particular hospitalization.
10. Claim documents will be forwarded to on duty doctor who will verify your coverage as per respective insurance policy and medical admissibility. If covered an authorization letter (AL) will be sent (faxed) to hospital and copy to you if you so desire. All authorized amounts are subject to agreed tariffs
11. In case there is a deficiency, it will be raised in the form of an additional information letter & faxed to respective Hospital. The query & claim status can be obtained from Hospital itself or Call Centre or on the website.
12. On receipt of deficient documents claim will be reviewed & processed further on as per admissibility.
13. If the coverage is not established, Intimation (Denial) will be sent to the hospital.
14. In certain instances Insured details may no be available & case will be forwarded to Data Not Found (DNF) Cell. Updating is subject to provision of policy details by respective Insurance Company. After updating data claim will be processed accordingly. In case of corporate claims member can follow up / approach their HR.
15. The denial of authorization for cashless access does not mean denial of treatment and does not in any way prevent you from seeking necessary medical attention or hospitalization.
16. Cases wherein the claim is denied for cashless benefit Claimant / Insured can send all claim documents for reconsideration in reimbursement along with claim form. Defined in "What documents are required to be submitted under a claim"

INCASE OF PLANNED HOSPITALISATION (to a Network Hospital)

Notify Paramount at least 3 days prior to the date of admission

1. Kindly send the completely filled hospitalization request note either by Fax or by E-Mail.
2. Claims arising from Mumbai will be handled / processed at Mumbai. Claims arising from other locations can contact local PHS office or the helpline.
3. If the ailment is covered under policy conditions, an Authority Letter would be issued to the concerned hospital enabling you cashless facility.
4. In case of any deficiency or query, an additional information letter will be sent to the Hospital. On retrieval of the said information the request will be processed accordingly.

If the coverage is not established, Intimation (Denial) will be sent to the hospital.

WHAT TO DO IN AN EMERGENCY?

1. In an accidental case or in medical emergency you are advised to approach nearest Network / Non Network Hospital with your PHS ID Card.

Network Hospital

1. If the admittance is in a network hospital, pre-intimation can be made by the claimant or relatives by calling up PHS (Helpdesk is open 24 X 7).
2. However it is still mandatory to send admission request note for processing & consideration of case under cashless benefit.
3. PHS will verify the coverage (both insurance & medical aspect) and if covered issue the authority letter to network hospital.

Non Network Hospital

1. If you are in non-network hospital you may pay the expenses and claim reimbursement based on policy coverage.
2. You may get admitted as per the rules of the Hospital and make payments for the treatment taken and later on submit all the documents for reimbursement.

IN THE HOSPITAL

1. The network hospital you have chosen will treat you without asking for deposit & payment of hospital bills will be up to the guaranteed (authorized) amount, the maximum liability being limit of indemnity subject to the coverage under the applicable policy terms and conditions.
2. The claims will be settled as per agreed rates & package prices notwithstanding the amount sanctioned.
3. Certain tertiary care hospitals will ask for some nominal deposit as per their protocol irrespective of approval of cashless guarantee to take care of non-covered expenses.
4. If you are required to buy medicine or investigation done outside the hospital, kindly obtain proper Cash Memo / Receipt for payment made by you. (The same can be claimed under reimbursement following discharge)
5. Certain charges such as (Telephone / Fax, Food & Beverages for relatives, Barber, Ambulance etc.) are not covered under your insurance policy; if you have obtained such services from the hospital please pay for the same directly to the hospital.

6. The policy which you have purchased may also contain certain additional clause like co-pay, room restriction, etc which will be applied while sanctioning cashless. All such expenses need to be paid by Insured to hospital prior to discharge & will not be reimbursed as per the terms and conditions of the applicable policy.

AT THE TIME OF DISCHARGE

1. The hospital will discharge you without payment of the bills, except non-payable expenses, on the basis of A/L issued.
2. If the bill amount exceeds the limit of indemnity, you will have to pay settle over & above amount to hospital.
3. Network hospital, wherein you have availed cashless benefit, will not give you the Original Bill, Discharge Card, Investigation Reports, etc. (as they have to send these to PHS) however you may ask for copies of the same for your records & subsequent follow-up
4. Hospital may charge you a token amount for issuing duplicates
5. Prior to discharge insured should verify the Final Bill & duly sign the same.

Procedure for Reimbursement cases

Reimbursement claims can be submitted to PHS through courier, post or In Person at any of our Branches

Claim Documents should be sent to PHS within 15 days from the Date of Discharge.(or as per policy T & C)

Claim form can be collected from the nearest Divisional / Branch Office of the Insurance company / PHS office. Claim forms can be downloaded from our website i.e.paramounttpa.com. Issuance of claim form does not amount to admission of any liability, under the policy on the part of the insurers.

1. Documents that you need to submit for a hospitalization reimbursement claim are:

1. Original Completely filled in Claim form
2. Covering letter stating your complete address, contact numbers and email address (if available), along with Schedule of Expenses
3. Copy of the PHS ID card or current policy copy and previous years' policy copies (if any)
4. Original Discharge Card/ Summary

5. Original hospital final bill
6. Original numbered receipts for payments made to the hospital
7. Complete breakup of the hospital bill
8. All bills for investigations done with the respective reports
9. All bills for medicines supported by relevant prescriptions

2. On receipt of claim at PHS, Medical team at PHS will determine whether the condition requiring admission and the treatment are covered by your health insurance policy. They will also check with all the other terms and conditions of your insurance policy. Non-medical expenses will not be payable.

3. Based on the processing of the claim, a denial or approval is executed. In case of approval, a cheque is made out for the approved amount and sent to you at the address mentioned in your health insurance policy. In case you have been insured through your Employer, the cheque will be dispatched based on instructions received from your Employer.

4. In case your claim is denied, the denial letter is sent to you by courier / post / e-mail quoting the reason for denial of your claim. In case you have been insured through your Employer, the denial letter will be dispatched based on instructions received from your Employer.

Note: Only expenses relating to hospitalisation will be reimbursed as per the policy taken. All non-medical expenses will not be reimbursed.

How does one get Reimbursement for pre and post hospitalisation expenses under this scheme?

The medical expenses incurred prior to Hospitalisation are called Pre-hospitalisation expenses and those incurred
subsequent to discharge as Post Hospitalisation expenses.

Mediclaim Policy allows reimbursement of medical expenses incurred prior to certain days of hospitalization & up to a
certain number of days after discharge, provided the ailment/ disease for which hospitalisation is covered under the policy Terms & Conditions.

These days are subject to the limits as described in your respective policy.

For claiming all Pre-Post Hospitalisation expenses

You need to send all bills in original with supporting documents in the following manner:

1. Consultation bills should be supported with consultation note / papers of the doctor.
2. Investigation / Pathological / Radiological test bills should be supported along with Reports & advice for the same.
3. Chemist bills should be supported with respective prescriptions for the same.
4. Copy of Discharge Card of the Hospitalisation.
5. Claim must be sent within 7 days from the completion of Treatment Or within 7 days from completion of Post Hospitalisation Benefit in your policy, the limit of Post

IN CAES OF ANY QUERY YOU CAN VISIT OUR WEBSITE i.e.www.paramounttpa.com OR YOU CAN AVAIL ANY KIND OF HELP FROM OUR 24*7 CALL CENTER.
CAL CENTER NO – 66620808 AND TOLL FREE NO – 1800-22-66-55