



Paramount TPA Portal

User Manual

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- Claim Submission-Deficiency Claim

Claim Submission

Click here to Submit GMC Policy, Covid Policy, Parent in law Policy, Pre –post Hospitalization, or Deficiency claims.



Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006 (Valid upto 20.03.2023)

HI, TEST EMPLOYEE 
[LogOut](#)



Online Enrollment



Beneficiary Details & E-card



Claim Submission



Track Claim Details



Hospital Network



Claim Procedure



Policy Benefits & FAQ



Wellness



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Useful Links

- [Mobile App](#) →
- [Checklist](#) →
- [TPA branches](#) →

Claim Submission -GMC Policy

Click here to upload the claims

Paramount Health Services & Insurance
IDA License No: 008 (Valid upto 2022)

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Logout

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Hospital Network | Claim Procedure | Policy Benefits & FAQ | Wellness

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Useful Links
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Dashboard > Claim Submission

GMC policy Claim Submission					Covid Policy Claim Submission	Parent In Law Policy	Pre Post Hospitalization	Deficiency Claim
Name	Gender	Date of Birth	Age	Relation	Action			
Test Employee	Male	21-Jul-1982	39	Employee	Upload IPD Claim	Upload OPD/Dental/Vision Claim		
Test Wife	Female	24-Feb-1986	36	Wife	Upload IPD Claim	Upload OPD/Dental/Vision Claim		
Test Son	Male	15-Jan-2019	3	Son	Upload IPD Claim	Upload OPD/Dental/Vision Claim		
Test Father	Male	01-Mar-1947	75	Father	Upload IPD Claim	Upload OPD/Dental/Vision Claim		

Click here to upload IPD claim

Click here to upload OPD/Dental/Vision Claim

Upload IPD Claim-Step 1: Patient Details

Step 1:

Dashboard > Claim Submission

GMC policy Claim Submission		Covid Policy Claim Submission		Parent in Law Policy		Pre Post Hospitalization		Deficiency Claim	
Name	Gender	Date of Birth	Age	Relation	Action				
Test Employee	Male	21-Jul-1982	39	Employee	Upload IPD Claim	Upload OPD/Dental/Vision Claim			
Test Wife	Female	24-Feb-1986	38	Wife	Upload IPD Claim	Upload OPD/Dental/Vision Claim			
Test Son	Male	15-Jan-2019	3	Son	Upload IPD Claim	Upload OPD/Dental/Vision Claim			
Test Father	Male	01-Mar-1947	75	Father	Upload IPD Claim	Upload OPD/Dental/Vision Claim			

Click here to Upload IPD claim

Patient Details

Disclaimer

Claim Form

Bank Details

Upload Document

Patient Details

All fields marked * are mandatory.

Patient Name: TEST EMPLOYEE Date of Birth: 21/07/1982 Age: 39 Gender: MALE

PHS ID: 3963262 TPA Claim No.: 0 TPA Claim Ext.: Relation With Insured: EMPLOYEE

Date Of Admission Date of Discharge

Please select the Date of Admission

Please select the Date of Discharge

Next

Click "Next"

- To upload IPD claims in GMC Policy, Click Upload IPD claim tab.
- Select Date of Admission and Date of Discharge.
- Click “ Next”.

Step 2: Self Declaration

Step 2 :

- After clicking “Next”
- Click Agree & Next, To go for next step.
- Click Print, To Print Self declaration document
- To move to previous page click “Previous’ tab.

Disclaimer

To:
Paramount Health Services & Insurance Pvt. Ltd.
..... (Branch)

Self declaration

I do hereby solemnly affirm and declare on under that:

1. I **TEST EMPLOYEE** hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy no. No. **00220/0022/00000790** .
2. I hereby declare that I shall not produce or claim the physical copy of the electronically submitted claim documents submitted to Paramount Health Services & Insurance (Pvt. Ltd (attached herewith) at any other Insurer/ IFA for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
3. I shall ensure that I have copy of scanned hospitalization documents shall be submitted to the **Virtual Helpdesk** within **30 days** from the date of uploading the claim file on the portal.
4. I further ensure that I shall reimburse or indemnify the Insurance Company for the claim amount in case of a fraudulent duplicate, forged and manipulated claim submission or if this self-declaration is found untrue and dishonest.

Sincerely,

Name & Signature of the Claimant

Place -
Date -

Note -

1. This declaration for scanned claim documents submission is Valid till the lock down is lifted.
2. All claim documents shall be self attested and to be submitted along with the signed declaration and self attested Identity Proof.

Insurer Guidelines
NATIONAL INSURANCE COMPANY LTD.

- The Claim will be processed based on the complete set of scanned documents uploaded by the Insured through this portal. In case of any deficient document/requirement, we may raise the query & process further on receipt of those documents.
- In the meantime, Insured has to submit the Original Claim documents at the nearest Paramount branch
- Insured will not be claiming for the same hospitalization with any other insurance Company/IFA or anywhere else for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover the claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice
- Intimation of claim should be made to IFA through Email, Call, portal, or mobile app as per the defined timeline.
- All documents submitted as scanned copies should be self-attested by insured

Click here to move previous step

Previous Print Agree & Next

Click here, To Print the Self declaration Document

Click here to go for next step

Step 3: Claim Form –Part-A

Step 3 :

- Please Enter the Employee Name , E-mail id and Phone no.
- Please Enter E-mail id in Details of insured person hospitalized.
- Please Select the name of the hospital where Admitted.

Claim Form

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED

Reimbursement (To be filled in block letters)

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED:

a) Policy No: R0220050220000730
b) SI No/ Certificate No: [Redacted] c) Phs No/ IPA ID No: 3983262

Employee: TEST EMPLOYEE

a) Address: [Redacted]
City: [Redacted] State: [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Please fill the Mandatory fields

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/YYYY
c) If yes, company name: [Redacted] Policy No: R0220050220000730 Sum Insured (rs): [Redacted]
d) Have you been hospitalized in the last four years since inception of the contract? Yes No
Date: M: [Redacted] Y: [Redacted] Diagnosis: [Redacted]
e) Previously covered by any other Mediclaim / Health insurance: Yes No
f) If yes, Company Name: [Redacted]

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: TEST EMPLOYEE
b) Gender: Male Female c) Age: years [Redacted] months [Redacted] d) Date of Birth: 21/07/1982
e) Relationship to Primary insured: Self Spouse Child Other Mother Other
(Please Specify) [Redacted]
f) Occupation: Service Self Employed Homemaker Student Retired Other
(Please Specify) [Redacted]
g) Address (if different from above): [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Fill the Mandatory Fields

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: [Redacted] Search Hospital
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/YYYY
e) Date of Admission: 27/09/2022 f) Time: Hrs: [Redacted] Min: [Redacted] g) Date of Discharge: 30/09/2022 h) Time: Hrs: [Redacted] Min: [Redacted]
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse Alcohol Consumption
i. If Medico legal: Yes No ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No
j) System of Medicine: [Redacted]

Step 3: Claim Form-Part- A

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

Sr no.	Expense	Rs.
i	Pre-hospitalization Expenses	
ii	Hospitalization Expenses	
iii	Post-hospitalization Expenses	
iv	Ambulance Charges	
v	Others (code)	
Total		
vi	Pre-hospitalization period: Days	
vii	Post-hospitalization period: Days	

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

c) Details of Lump sum / cash benefit claimed

Sr no.	Expense	Rs.
i	Hospital Daily Cash	
ii	Surgical Cash	
iii	Critical Illness Benefit	
iv	Convalescence	
v	Pre/Post hospitalization Lump sum benefit	
vi	Others (code)	
Total		

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Pre-hospitalization Bills: Nos	
2		D D M M Y Y		Hospital Main Bill	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Post-hospitalization Bills: Nos	
5		D D M M Y Y		Pharmacy Bills	
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form 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 forfeited. I also consent & authorize 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 I will not be making any supplementary claim except the pre/post-hospitalization claim, if any

Signature of the Insured →

Date

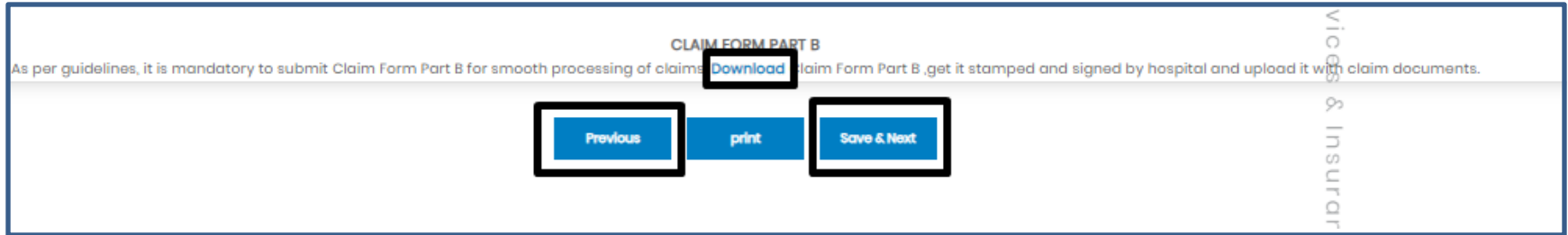
Place

Please Enter the Total Amount

Total

- Please Enter the Total Amount.
- Enter the Place
- Fill the Signature of Insured.

Step 3: Claim Form –Part B



- Click Download option, to download the Part-B form.
- To go for step 2 Click previous button
- To Take print of claim form ,Click print button
- To go for the next step click Save & Next button

Note: As per Guidelines, It is mandatory to Submit Claim Form part-B for smooth processing. Download the form and get it stamped and signed by Hospital and upload it with claim Documents

Step 4: Bank Details

Step 4 :

The screenshot shows a web form titled "Bank Details". At the top, there is a red instruction: "Please enter the employee's PAN details if the claim amount is greater than 1lac." The form contains several input fields: "Account No." (with a sub-field "Account No."), "Re-enter Account No." (with a sub-field "Re-enter Account No."), "Name as per the Bank Account" (with a sub-field "Name as per the Bank Account"), "IFSC Code" (with a sub-field "IFSC Code"), "Bank Name & Branch" (with a sub-field "Bank Name and Branch"), and "PAN No." (with a sub-field "0"). Below these fields is an "Upload Cancelled cheque" section with a "Choose File" button and the text "No file chosen". A blue link "View Document" is also present. At the bottom of the form, there are two buttons: "Previous" and "Save & Next". Annotations include a box "Click here to upload cancelled cheque" pointing to the "Choose File" button, a box "To go to pervious page, Click here" pointing to the "Previous" button, and a box "Click here, to Move next page" pointing to the "Save & Next" button.

- Bank details to be filled only once or while filling the first claim.
- For Subsequent claims, the fields will be auto populated.
- Please Upload Cancelled cheque.
- Please enter the employee's PAN details if the claim is greater than 1lac.

Step 5: Upload Document

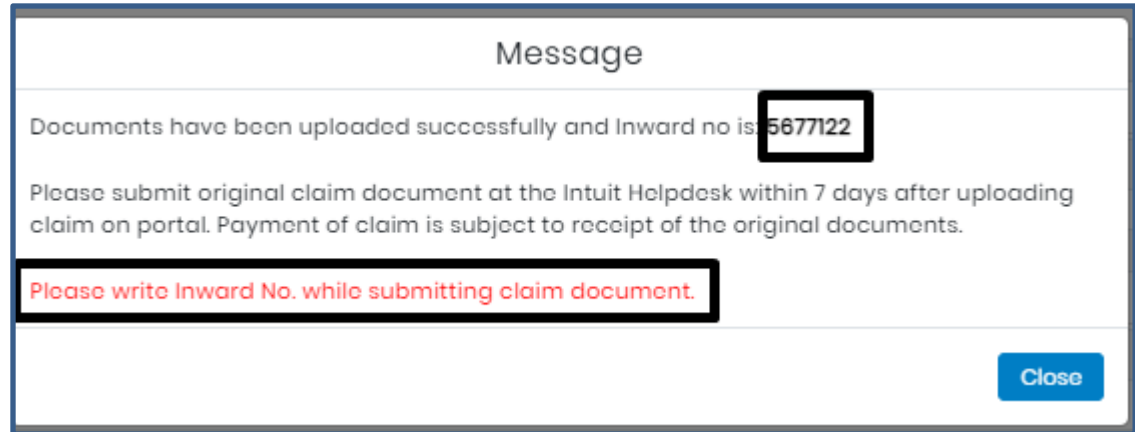
Step 5 :

The screenshot shows the 'Upload Document' section of a web application. At the top, there are five navigation tabs: Patient Details, Disclaimer, Claim Form, Bank Details, and Upload Document. The 'Upload Document' tab is active. Below the tabs, there are instructions: 'Upload pdf/jpg format documents only.' and 'The PDF file should not exceed more than 12 Mb.' A table lists documents with columns for 'Sr. No.', 'Document Name', and actions. Annotations include: 'Click here to View Claim form' pointing to the 'View' button for the first document; 'Click here to View Neft details' pointing to the 'View' button for the third document; 'Click here to Delete' pointing to the 'Delete' button for the third document; 'Click here to move to previous page' pointing to the 'Previous' button; 'Click here to Submit' pointing to the 'Submit Claim' button; 'Click Arrow button to Upload documents' pointing to the 'Upload' button in the table; and 'Click here to delete the documents' pointing to the 'Delete' button in the table.

Sr. No.	Document Name	View	Delete
1	claim Form Name 99023291_CLAIMFORM.pdf	View	Delete
2	KYC DOCUMENTS		
3	NEFT DOCUMENTS Name 99023291_NEFT.JPEG	View	Delete
4	DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY		
5	FINAL HOSPITAL BILL		
6	INVESTIGATION REPORT		
7	MEDICINE PRSCRIPTION		
8	Other		

- ❑ If you have more documents / receipts in claim, to share the claim Number and email Paramount on helpdesk.intuit@paramounttpa.com

- After Clicking the submit tab POP-UP appears.
- Please Use this Inward No. for further correspondence and to track your claim till claim No. is generated.
- It takes 24-48 Hours to generate Claim No.
- In case Claim No. is not generated within 24hrs please write a mail to-
helpdesk.intuit@paramounttpa.com



Upload OPD/Dental/Vision claims

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006 (Valid upto 20.03.2023)

Online Enrollment Beneficiary Details & E-card Claim Submission Track Claim Details

Hospital Network Claim Procedure Policy Benefits & FAQ Wellness

Contact Us Downloads

Useful links

- Mobile App
- Checklist
- TPA branches

Click here to upload OPD claims

Dashboard > Claim Submission

GMC policy Claim Submission Covid Policy Claim Submission Parent In Low Policy Pre Post Hospitalization Deficiency Claim

Name	Gender	Date of Birth	Age	Relation	Action
Test Employee	Male	21-Jul-1982	39	Employee	Upload IPD Claim Upload OPD/Dental/Vision Claim
Test Wife	Female	24-Feb-1986	36	Wife	Upload IPD Claim Upload OPD/Dental/Vision Claim
Test Son	Male	15-Jan-2019	3	Son	Upload IPD Claim Upload OPD/Dental/Vision Claim
Test Father	Male	01-Mar-1947	75	Father	Upload IPD Claim Upload OPD/Dental/Vision Claim

Click here to upload OPD/Dental/ vision claims

Step 1: Patient Details

Step 1:

Dashboard > Claim Submission

GMC policy Claim Submission Covid Policy Claim Submission Parent In Low Policy Pre Post Hospitalization Deficiency Claim

Name	Gender	Date of Birth	Age	Relation	Action
Test Employee	Male	21-Jul-1962	39	Employee	Upload IPD Claim Upload OPD/Dental/Vision Claim
Test Wife	Female	24-Feb-1966	36	Wife	Upload IPD Claim Upload OPD/Dental/Vision Claim
Test Son	Male	15-Jan-2019	3	Son	Upload IPD Claim Upload OPD/Dental/Vision Claim
Test Father	Male	01-Mar-1947	75	Father	Upload IPD Claim Upload OPD/Dental/Vision Claim

Click here to upload OPD/Dental/ Vision claims

Progress bar: Patient Details (active), Disclaimer, Claim Form, Bank Details, Upload Document

Patient Details

All fields marked * are mandatory.

Patient Name :	TEST EMPLOYEE	Date of Birth :	21/07/1962	Age :	39	Gender :	MALE
PHS ID :	3963262	TPA Claim No. :	5694652	TPA Claim Ext. :		Relation With Insured :	EMPLOYEE

Date of Consultation

Please select the Date of Consultation

Next

- After clicking Upload OPD/Dental/ Vision tab
- Please select Date of Consultation.
- Click “Next”

Step 2: Self Declaration

Step 2 :

- After clicking “Next”
- Click Agree & Next, To go for next step.
- Click Print, To Print Self declaration document
- To move to previous page click “Previous’ tab.

Disclaimer

To:
Paramount Health Services & Insurance Pvt Ltd.
..... (Branch)

Self-declaration

I do hereby solemnly affirm and declare on under that:

1. **TEST EMPLOYEE** hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy no: **802202/0422/0000793**.
2. I hereby declare that I shall not produce or claim the physical copy of the electronically submitted claim documents submitted to Paramount Health Services & Insurance (Pvt) Ltd (attached herewith) at any other Insurer/ IFA for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
3. I shall ensure that I have copy of scanned hospitalization documents shall be submitted to the **Virtual Helpdesk** within **30 days** from the date of uploading the claim file on the portal.
4. I further ensure that I shall reimburse or indemnify the Insurance Company for the claim amount in case of a fraudulent duplicate, forged and manipulated claim submission or if this self-declaration is found untrue and dishonest.

Sincerely,

Name & Signature of the Claimant

Place -
Date -

Note -

1. This declaration for scanned claim documents submission is Valid till the lock down is lifted.
2. All claim documents shall be self attested and to be submitted along with the signed declaration and self attested Identity Proof.

Insurer Guidelines
NATIONAL INSURANCE COMPANY LTD.

- The Claim will be processed based on the complete set of scanned documents uploaded by the Insured through this portal. In case of any deficient document/requirement, we may raise the query & process further on receipt of those documents.
- In the meantime, Insured has to submit the Original Claim documents at the nearest Paramount branch
- Insured will not be claiming for the same hospitalization with any other insurance Company/IFA or anywhere else for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover the claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
- Intimation of claim should be made to IFA through Email, Call, portal, or mobile app as per the defined timeline.
- All documents submitted as scanned copies should be self-attested by insured.

Click here to move previous step

Previous Print Agree & Next

Click here, To Print the Self declaration Document

Click here to go for next step

Step 3: Claim form: Part-A

**OPD CLAIM FORM
PART - A**

Name of Policy Holder (Employee) : TEST EMPLOYEE
Policy Name : 802200/80/02/0000730
Pin ID : 398202
Policy Type : Individual Policy; Retail Policy; Group Policy; Corporate Policy
Company Name :
Employee Name : TEST EMPLOYEE Employee ID : 12345

A detail of insured person in respect to claim is made. (Patient's details)
Name of Insured : TEST EMPLOYEE
Relationship with Policy Holder : EMPLOYEE
Age : 39 Gender : MALE
Occupation : Service/Self Employed/home maker/Student/Retire/Other
Residential Address :
City : State : Pin Code :
Mobile No. : 9930389903 Landline No. :
E mail id : SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Nature of illness / disease contracted, or injury suffered for which insured has consulted
Nature of illness : Specify details whether it is OPD, Dental or Vision
Name of Treating Doctor : Contact No. :
Date of treatment : DD/MM/YYYY

Details of Amount Claim

Bill Heads	Bill Number	Bill Generation Date	Amount
Consultation Fees		DD/MM/YYYY	
Pharmacy Bills		DD/MM/YYYY	
Investigation Charges		DD/MM/YYYY	
Other (Ifs Specify)		DD/MM/YYYY	
Total Claim Amount			

In support to above claim, I enclose following documents.

- Bills/ Receipt/ Cash Memo in original for medicines etc
- Most recent medical prescription/ consultation papers in support of above
- Receipts and investigation test reports in original from a Pathological Lab supported by the note from treating doctor.
- Attending Doctor's/Consultant's/ Specialist's bill and receipt and certificate regarding diagnosis, whichever is prescribed and thereby expenses incurred along with Doctor's registration number (compulsory).

Mandatory Documents

1. Copy of Aadhar Card of employee
2. Copy of PAN Card employee

Declaration

I hereby agree, affirm and declare that -

1. The statements/information given in this claim form are true correct and complete.
2. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claims has been withheld or not disclosed.
3. If I have given/made any fraudulent statements or in any manner failed to disclose or in any manner fail to disclose material information, the policy shall be void and that I shall not be entitled to all/ any rights to recover there under in respect of any or all claims, past present or future.
4. I have not submitted any other claim under Out Patient Treatment Cover and shall not be submitting any other Outpatient Treatment Cover Claim in future under the above referred policy certificate.
5. The receipt of this claim form /other supporting / related documents does not constitute an agreement by the company of the claim and the company reserves the right to process or reject or require additional information in respect of the claim.
6. I also consent and authorize Insurance Company to seek medical information from any hospital/ medical practitioner who has any time attended on the insured person.
7. I confirm that the expenses for which claim is being lodged have been incurred in respect to the insured.

Date: 01/10/2022 Place: Signature Of Claimant:

[Previous](#) [print](#) [Save & Next](#)

Click here to move to previous step

To move to next, Click Save_Next

- Please Enter Mobile No.
- Enter Total Claim amount

- Fill Date & Signature of claimant
- Click "Save & Next"

Step 4: Bank Details

Step 4 :

The screenshot shows a web form titled "Bank Details". At the top, there is a red instruction: "Please enter the employee's PAN details if the claim amount is greater than 1lac." The form contains several input fields: "Account No." (with a sub-field "Account No."), "Re-enter Account No." (with a sub-field "Re-enter Account No."), "Name as per the Bank Account" (with a sub-field "Name as per the Bank Account"), "IFSC Code" (with a sub-field "IFSC Code"), "Bank Name & Branch" (with a sub-field "Bank Name and Branch"), and "PAN No." (with a sub-field containing the digit "0"). Below these fields is a section for "Upload Cancelled cheque" with a "Choose File" button and the text "No file chosen". A blue link "View Document" is also present. At the bottom of the form, there are two blue buttons: "Previous" and "Save & Next". Annotations include a box "Click here to upload cancelled cheque" pointing to the "Choose File" button, a box "To go to pervious page, Click here" pointing to the "Previous" button, and a box "Click here, to Move next page" pointing to the "Save & Next" button.

- Bank details to be filled only once or while filling the first claim.
- For Subsequent claims, the fields will be auto populated.
- Please Upload Cancelled cheque.
- Please enter the employee's PAN details if the claim is greater than 1lac.

Step 5: Upload Document

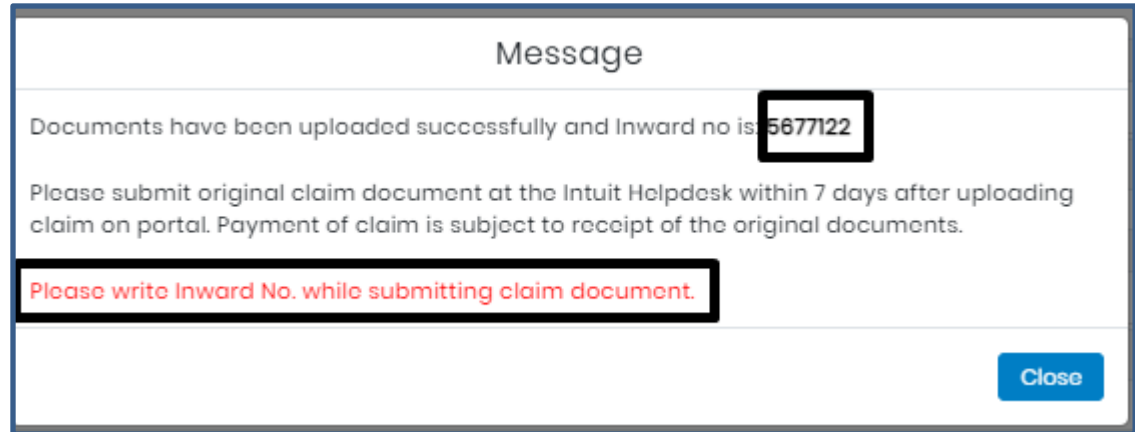
Step 5 :

The screenshot shows the 'Upload Document' section of a web application. At the top, there are five navigation tabs: Patient Details, Disclaimer, Claim Form, Bank Details, and Upload Document. The 'Upload Document' tab is active. Below the tabs, there are instructions: 'Upload pdf/jpg format documents only.' and 'The PDF file should not exceed more than 12 Mb.' A table lists documents with columns for 'Sr. No.', 'Document Name', and actions. Annotations include: 'Click here to View Claim form' pointing to a 'View' button; 'Click here to View Neft details' pointing to a 'View' button; 'Click here to Delete' pointing to a 'Delete' button; 'Click here to move to previous page' pointing to a 'Previous' button; 'Click here to Submit' pointing to a 'Submit Claim' button; 'Click Arrow button to Upload documents' pointing to an 'Upload' button; and 'Click here to delete the documents' pointing to a 'Delete' button. The table data is as follows:

Sr. No.	Document Name	View	Delete
1	claim Form Name 99023291_CLAIMFORM.pdf	View	Delete
2	KYC DOCUMENTS		
3	NEFT DOCUMENTS Name 99023291_NEFT.JPEG	View	Delete
4	DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY		
5	FINAL HOSPITAL BILL		
6	INVESTIGATION REPORT		
7	MEDICINE PRSCRIPTION		
8	Other		

- ❑ If you have more documents / receipts in claim, to share the claim Number and email Paramount on helpdesk.intuit@paramounttpa.com

- After Clicking the submit tab POP-UP appears.
- Please Use this Inward No. for further correspondence and to track your claim till claim No. is generated.
- It takes 24-48 Hours to generate Claim No.
- In case Claim No. is not generated within 24hrs please write a mail to-
helpdesk.intuit@paramounttpa.com



Claim Submission-Covid Policy Submission

Click Claim Submission to upload the Covid policy claims

Paramount Health Services & Insurance
HDA License No. 038 (Valid upto 30.03.2023)

HI TEST EMPLOYEE
Logout

Online Enrollment | Beneficiary Details & E-card | **Claim Submission** | Track Claim Details

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Dashboard > Claim Submission

GMC policy Claim Submission | **Covid Policy Claim Submission** | Parent in Law Policy | Pre Post Hospitalization | Deficiency Claim

Name	Gender	Date of Birth	Age	Relation	Action
Test Employee	Male	21-Jul-1982	39	Employee	Upload Hospitalization Claim Home Isolation
Test Wife	Female	24-Feb-1986	36	Wife	Upload Hospitalization Claim Home Isolation
Test Son	Male	15-Jan-2019	3	Son	Upload Hospitalization Claim Home Isolation
Test Father	Male	01-Mar-1947	75	Father	Upload Hospitalization Claim Home Isolation

Click here to Upload Hospitalization claim

Click here to upload home isolation claim

Step 1: Patient Details(Hospitalization claims)

Dashboard > Claim Submission

Step 1: →

Click here to Upload Hospitalization Claims

Name	Gender	Date of Birth	Age	Relation	Action
Test Employee	Male	21-Jul-1982	39	Employee	Upload Hospitalization Claim Home Isolation
Test Wife	Female	24-Feb-1986	36	Wife	Upload Hospitalization Claim Home Isolation
Test Son	Male	15-Jan-2019	3	Son	Upload Hospitalization Claim Home Isolation
Test Father	Male	01-Mar-1947	75	Father	Upload Hospitalization Claim Home Isolation

Click here to Upload Hospitalization Claims

Click "Next"

Please select the Date of Admission

Please select the Date of Discharge

Next

Patient Details

Disclaimer

Claim Form

Bank Details

Upload Document

Patient Details

All fields marked * are mandatory.

Patient Name: TEST EMPLOYEE Date of Birth: 21/07/1982 Age: 39 Gender: MALE

PHS ID: 3963262 TPA Claim No.: 0 TPA Claim Ext.: Relation With Insured: EMPLOYEE

Date Of Admission dd/mm/yyyy Date of Discharge dd/mm/yyyy

- To upload Hospitalization claim in Covid Policy, Click Upload Hospitalization claim tab.
- Select Date of Admission and Date of Discharge.
- Click “ Next”.

Step 2: Self Declaration

Step 2 :

- After clicking “Next”
- Click Agree & Next, To go for next step.
- Click Print, To Print Self declaration document
- To move to previous page click “Previous’ tab.

Disclaimer

To:
Paramount Health Services & Insurance Pvt Ltd.
..... (Branch)

Self-declaration

I do hereby solemnly affirm and declare on under that:

1. I, **TEST EMPLOYEE** hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy No. **802200/0022/00000790**.
2. I hereby declare that I shall not produce or claim the physical copy of the electronically submitted claim documents submitted to Paramount Health Services & Insurance (Pvt) Ltd (attached herewith) at any other Insurer/ IFA for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherever the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
3. I shall ensure that I have copy of scanned hospitalization documents shall be submitted to the **Virtual Helpdesk** within **30 days** from the date of uploading the claim file on the portal.
4. I further assure that I shall reimburse or indemnify the Insurance Company for the claim amount in case of a fraudulent duplicate, forged and manipulated claim submission or if this self-declaration is found untrue and dishonest.

Sincerely,

Name & Signature of the Claimant

Place -
Date -

Note -

1. This declaration for scanned claim documents submission is Valid till the lock down is lifted.
2. All claim documents shall be self attested and to be submitted along with the signed declaration and self attested Identity Proof.

Insurer Guidelines
NATIONAL INSURANCE COMPANY LTD.

- The Claim will be processed based on the complete set of scanned documents uploaded by the Insured through this portal. In case of any deficient document/requirement, we may raise the query & process further on receipt of those documents.
- In the meantime, Insured has to submit the Original Claim documents at the nearest Paramount branch
- Insured will not be claiming for the same hospitalization with any other insurance Company/IFA or anywhere else for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover the claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherever the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice
- Intimation of claim should be made to IFA through Email, Call, portal, or mobile app as per the defined timeline.
- All documents submitted as scanned copies should be self-attested by insured.

Click here to move previous step

Previous Print Agree & Next

Click here to go for next step

Click here, To Print the Self declaration Document

Step 3: Claim Form –Part-A

Step 3 :

- Please Enter the Employee Name , E-mail id and Phone no.
- Please Enter E-mail id in Details of insured person hospitalized.
- Please Select the name of the hospital where Admitted.

Claim Form

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED

Reimbursement (To be filled in block letters)

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED:

a) Policy No: R0220050220000730
b) SI No/ Certificate No: [Redacted] c) Phs No/ IPA ID No: 3983262

Employee: TEST EMPLOYEE

a) Address: [Redacted]
City: [Redacted] State: [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Please fill the Mandatory fields

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/YYYY
c) If yes, company name: [Redacted] Policy No: R0220050220000730 Sum Insured (rs): [Redacted]
d) Have you been hospitalized in the last four years since inception of the contract? Yes No
Date: M: [Redacted] Y: [Redacted] Diagnosis: [Redacted]
e) Previously covered by any other Mediclaim / Health insurance: Yes No
f) If yes, Company Name: [Redacted]

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: TEST EMPLOYEE
b) Gender: Male Female c) Age: years [Redacted] months [Redacted] d) Date of Birth: 21/07/1982
e) Relationship to Primary insured: Self Spouse Child Other Mother Other
(Please Specify) [Redacted]
f) Occupation: Service Self Employed Homemaker Student Retired Other
(Please Specify) [Redacted]
g) Address (if different from above): [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Fill the Mandatory Fields

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: [Redacted] Search Hospital
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/YYYY
e) Date of Admission: 27/09/2022 f) Time: Hrs: [Redacted] Min: [Redacted] g) Date of Discharge: 30/09/2022 h) Time: Hrs: [Redacted] Min: [Redacted]
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse Alcohol Consumption
i. If Medico legal: Yes No ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No
j) System of Medicine: [Redacted]

Step 3: Claim Form-Part- A

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

Sr no.	Expense	Rs.
i	Pre-hospitalization Expenses	
ii	Hospitalization Expenses	
iii	Post-hospitalization Expenses	
iv	Ambulance Charges	
v	Others (code) <input type="text"/> <input type="text"/> <input type="text"/>	
Total		
vi	Pre-hospitalization period: Days <input type="text"/> <input type="text"/> <input type="text"/>	
vii	Post-hospitalization period: Days <input type="text"/> <input type="text"/> <input type="text"/>	

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

c) Details of Lump sum / cash benefit claimed

Sr no.	Expense	Rs.
i	Hospital Daily Cash	
ii	Surgical Cash	
iii	Critical Illness Benefit	
iv	Convalescence	
v	Pre/Post hospitalization Lump sum benefit	
vi	Others (code) <input type="text"/> <input type="text"/> <input type="text"/>	
Total		

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Pre-hospitalization Bills: Nos	
2		D D M M Y Y		Hospital Main Bill	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Post-hospitalization Bills: Nos	
5		D D M M Y Y		Pharmacy Bills	
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form 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 forfeited. I also consent & authorize 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 I will not be making any supplementary claim except the pre/post-hospitalization claim, if any

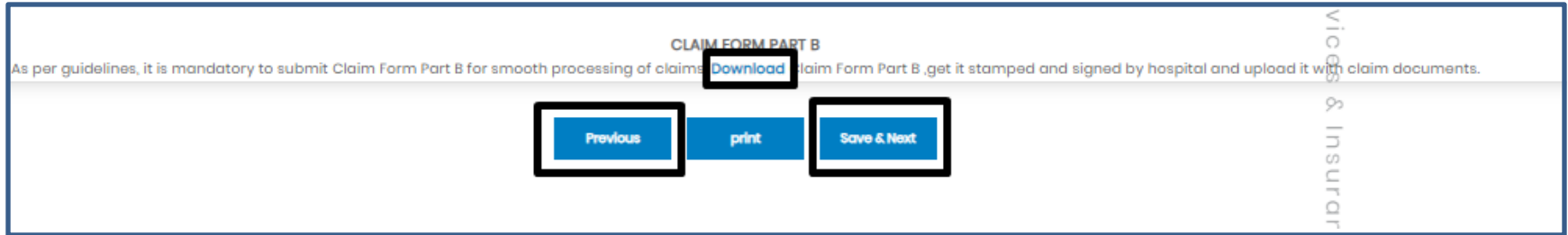
Signature of the Insured

Date

Please Enter the Total Amount →

- Please Enter the Total Amount.
- Enter the Place
- Fill the Signature of Insured.

Step 3: Claim Form –Part B



- Click Download option, to download the Part-B form.
- To go for step 2 Click previous button
- To Take print of claim form ,Click print button
- To go for the next step click Save & Next button

Note: As per Guidelines, It is mandatory to Submit Claim Form part-B for smooth processing. Download the form and get it stamped and signed by Hospital and upload it with claim Documents

Step 4: Bank Details

Step 4 :

The screenshot shows a web form titled "Bank Details". At the top, there is a red instruction: "Please enter the employee's PAN details if the claim amount is greater than 1lac." The form contains several input fields: "Account No." (with a sub-field "Account No."), "Re-enter Account No." (with a sub-field "Re-enter Account No."), "Name as per the Bank Account" (with a sub-field "Name as per the Bank Account"), "IFSC Code" (with a sub-field "IFSC Code"), "Bank Name & Branch" (with a sub-field "Bank Name and Branch"), and "PAN No." (with a sub-field "0"). Below these fields is an "Upload Cancelled cheque" section with a "Choose File" button and the text "No file chosen". A blue link "View Document" is also present. At the bottom of the form, there are two buttons: "Previous" and "Save & Next". Annotations include a box "Click here to upload cancelled cheque" pointing to the "Choose File" button, a box "To go to pervious page, Click here" pointing to the "Previous" button, and a box "Click here, to Move next page" pointing to the "Save & Next" button.

- Bank details to be filled only once or while filling the first claim.
- For Subsequent claims, the fields will be auto populated.
- Please Upload Cancelled cheque.
- Please enter the employee's PAN details if the claim is greater than 1lac.

Step 5: Upload Document

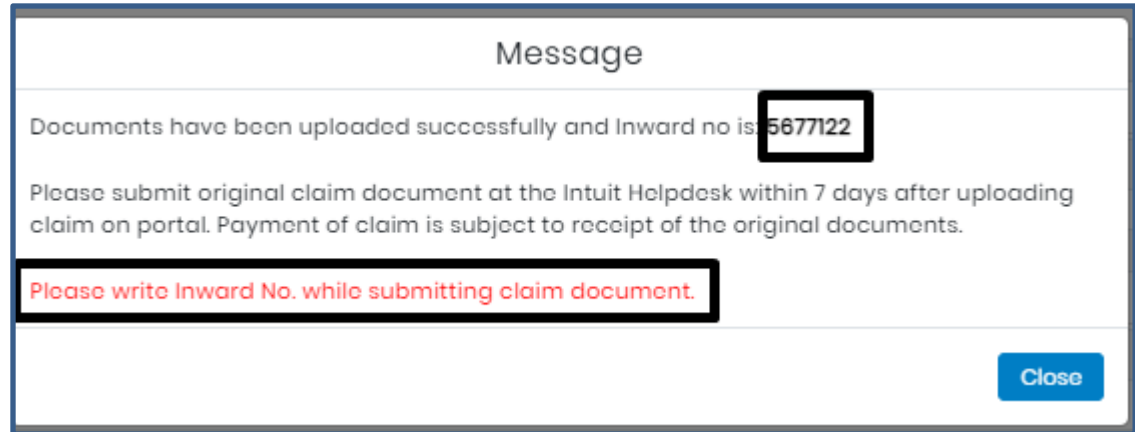
Step 5 :

The screenshot shows the 'Upload Document' section of a web application. At the top, there are five navigation tabs: Patient Details, Disclaimer, Claim Form, Bank Details, and Upload Document. The 'Upload Document' tab is active. Below the tabs, there are instructions: 'Upload pdf/jpg format documents only.' and 'The PDF file should not exceed more than 12 Mb.' A table lists documents with columns for 'Sr. No.', 'Document Name', and actions. Annotations include: 'Click here to View Claim form' pointing to a 'View' button; 'Click here to View Neft details' pointing to a 'View' button; 'Click here to Delete' pointing to a 'Delete' button; 'Click here to move to previous page' pointing to a 'Previous' button; 'Click here to Submit' pointing to a 'Submit Claim' button; 'Click Arrow button to Upload documents' pointing to an 'Upload' button; and 'Click here to delete the documents' pointing to a 'Delete' button. The table data is as follows:

Sr. No.	Document Name	View	Delete
1	claim Form Name 99023291_CLAIMFORM.pdf	View	Delete
2	KYC DOCUMENTS		
3	NEFT DOCUMENTS Name 99023291_NEFT.JPEG	View	Delete
4	DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY		
5	FINAL HOSPITAL BILL		
6	INVESTIGATION REPORT		
7	MEDICINE PRSCRIPTION		
8	Other		

- ❑ If you have more documents / receipts in claim, to share the claim Number and email Paramount on helpdesk.intuit@paramounttpa.com

- After Clicking the submit tab POP-UP appears.
- Please Use this Inward No. for further correspondence and to track your claim till claim No. is generated.
- It takes 24-48 Hours to generate Claim No.
- In case Claim No. is not generated within 24hrs please write a mail to-
helpdesk.intuit@paramounttpa.com



Claim submission-covid policy (Home Isolation claims)

Click Claim Submission to upload the covid policy claims

Paramount Health Services & Insurance
RDA License No. 038 (Valid upto 30.03.2023)

HI TEST EMPLOYEE Logout

Online Enrollment | Beneficiary Details & E-card | **Claim Submission** | Track Claim Details

Hospital Network | Claim Procedure | Policy Benefits & FAQ | Wellness

Contact Us | Downloads

Useful Links
Mobile App --
Checklist --
TPA branches --

Dashboard > Claim Submission

GMC policy Claim Submission | **Covid Policy Claim Submission** | Parent In Law Policy | Pre Post Hospitalization | Deficiency Claim

Name	Gender	Date of Birth	Age	Relation	Action
Test Employee	Male	21-Jul-1982	39	Employee	Upload Hospitalization Claim Home Isolation
Test Wife	Female	24-Feb-1986	36	Wife	Upload Hospitalization Claim Home Isolation
Test Son	Male	15-Jan-2019	3	Son	Upload Hospitalization Claim Home Isolation
Test Father	Male	01-Mar-1947	75	Father	Upload Hospitalization Claim Home Isolation

Click here to upload Home Isolation Claims

Step 1: Upload Home Isolation Claims

Dashboard > Claim Submission

[GMC policy Claim Submission](#) [Covid Policy Claim Submission](#) [Parent In Law Policy](#) [Pre Post Hospitalization](#) [Deficiency Claim](#)

Name	Gender	Date of Birth	Age	Relation	Action
Test Employee	Male	21-Jul-1982	39	Employee	Upload Hospitalization Claim Home Isolation
Test Wife	Female	24-Feb-1986	36	Wife	Upload Hospitalization Claim Home Isolation
Test Son	Male	15-Jan-2019	3	Son	Upload Hospitalization Claim Home Isolation
Test Father	Male	01-Mar-1947	75	Father	Upload Hospitalization Claim Home Isolation

[Click here to upload Home Isolation Claims](#)

[Patient Details](#) [Disclaimer](#) [Claim Form](#) [Bank Details](#) [Upload Document](#)

Patient Details

All fields marked * are mandatory.

Patient Name :	TEST EMPLOYEE	Date of Birth :	21/07/1982	Age :	39	Gender :	MALE
PHS ID :	3963261	TPA Claim No. :	0	TPA Claim Ext. :		Relation With Insured :	EMPLOYEE

[Next](#) Please check the Patient Details and Click "Next"

Step 2: Self Declaration

Step 2 :

- After clicking “Next”
- Click Agree & Next, To go for next step.
- Click Print, To Print Self declaration document
- To move to previous page click “Previous’ tab.

Disclaimer

To,
Paramount Health Services & Insurance Pvt Ltd.
..... (Branch)

Self declaration

I do hereby solemnly affirm and declare on under that:

1. I, **TEST EMPLOYEE** hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy no. **802202/0422/0000793**.
2. I hereby declare that I shall not produce or claim the physical copy of the electronically submitted claim documents submitted to Paramount Health Services & Insurance (Pvt) Ltd (attached herewith) at any other Insurer/ IFA for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherever the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
3. I shall ensure that I have copy of scanned hospitalization documents shall be submitted to the **Virtual Helpdesk** within **30 days** from the date of uploading the claim file on the portal.
4. I further ensure that I shall reimburse or indemnify the Insurance Company for the claim amount in case of a fraudulent duplicate, forged and manipulated claim submission or if this self-declaration is found untrue and dishonest.

Sincerely,

Name & Signature of the Claimant

Place -
Date -

Note -

1. This declaration for scanned claim documents submission is Valid till the lock down is lifted.
2. All claim documents shall be self attested and to be submitted along with the signed declaration and self attested Identity Proof.

Insurer Guidelines
NATIONAL INSURANCE COMPANY LTD.

- The Claim will be processed based on the complete set of scanned documents uploaded by the Insured through this portal. In case of any deficient document/requirement, we may raise the query & process further on receipt of those documents.
- In the meantime, Insured has to submit the Original Claim documents at the nearest Paramount branch.
- Insured will not be claiming for the same hospitalization with any other insurance Company/IFA or anywhere else for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present insurance policy is not sufficient to cover the claim amount fully and I have other insurance policies to cover balance claim amount from other same or different insurer wherever the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
- Intimation of claim should be made to IFA through Email, Call, portal, or mobile app as per the defined timeline.
- All documents submitted as scanned copies should be self-attested by insured.

Click here to move previous step

Previous Print Agree & Next

Click here to go for next step

Click here, To Print the Self declaration Document

Step 3: Claim Form: Part-A

Step 2 :

- Please Enter Mobile No.
- Enter Total Claim amount
- Fill Date&Signature of claimant
- Click “Save& Next”
-

**HOME ISOLATION CLAIM FORM
PART - A**

Name of Policy Holder/Employee : TEST EMPLOYEE
Policy Name : BH-22-DD400-00-00
PHS ID : 3903201
Policy Type : Individual Policy Retail Policy Group Policy Corporate Policy
Company Name : TEST EMPLOYEE Employee ID : 12345

A detail of insured person in respect to claim is made. (Patient's details)
Name of Insured : TEST EMPLOYEE
Relationship with Policy Holder : EMPLOYEE
Age : 39 Gender : MALE
Occupation : Self Employed Homemaker Student Retiree Other
Residential Address :
City : State : Pin Code :
Mobile No. : 9930308083 Landline No. :
E mail Id. : SHRADDHA.SHARMA@SPARAMOUNTTPA.COM

Nature of illness / disease contracted or injury suffered for which insured has consulted
Name of Treating Doctor : Contact No. :
Date of treatment : DD/MM/YYYY

Details of Amount Claim

Bill Heads	Bill Number	Bill Generation Date	Amount
Consultation Fees		DD/MM/YYYY	
Pharmacy Bills		DD/MM/YYYY	
Investigation Charges		DD/MM/YYYY	
Other (Pls Specify)		DD/MM/YYYY	
Total Claim Amount			

In support to above claim, I enclose following documents.

- Bills/ Receipt/ Cash Memo in original for medicines etc
- Most recent medical prescription/ consultation papers in support of above
- Receipts and investigation test reports in original from a Pathological Lab supported by the note from treating doctor.
- Attending Doctor's/consultant's/ Specialist's bill and receipt and certificate regarding diagnosis, whichever is prescribed and thereby expenses incurred along with Doctor's registration number (compulsory).

Mandatory Documents

1. Copy of Aadhar Card of employee
2. Copy of PAN Card employee

Declaration

I hereby agree, affirm and declare that -

1. The statements/information given in this claim form are true correct and complete.
2. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claims has been withheld or not disclosed.
3. If I have given/made any fraudulent statements or in any manner failed to disclose or in any manner fail to disclose material information, the policy shall be void and that I shall not be entitled to any rights to recover there under in respect of any or all claims, past present or future.
4. I have not submitted any other claim under Out Patient Treatment Cover and shall not be submitting any other Outpatient Treatment Cover Claim in future under the above referred policy certificate.
5. The receipt of this claim form /other supporting / related documents does not constitute an agreement by the company of the claim and the company reserves the right to process or reject or require additional information in respect of the claim.
6. I also consent and authorize Insurance Company to seek medical information from any hospital/ medical practitioner who has any time attended on the insured person.
7. I confirm that the expenses for which claim is being lodged have been incurred in respect to the insured.

Date : 01/10/2023 Place : Signature Of Claimant :

[Previous](#) [print](#) [Save & Next](#)

Click here to move to previous step To move to next, Click Save _Next

Step 4: Bank Details

Step 4 :

The screenshot shows a web form titled "Bank Details". At the top, there is a red instruction: "Please enter the employee's PAN details if the claim amount is greater than 1lac." The form contains several input fields: "Account No." (with a sub-field "Account No."), "Re-enter Account No." (with a sub-field "Re-enter Account No."), "Name as per the Bank Account" (with a sub-field "Name as per the Bank Account"), "IFSC Code" (with a sub-field "IFSC Code"), "Bank Name & Branch" (with a sub-field "Bank Name and Branch"), and "PAN No." (with a sub-field "0"). Below these fields is a section for "Upload Cancelled cheque" with a "Choose File" button and the text "No file chosen". A blue link "View Document" is also present. At the bottom of the form, there are two buttons: "Previous" and "Save & Next". Annotations include a box "Click here to upload cancelled cheque" pointing to the "Choose File" button, a box "To go to pervious page, Click here" pointing to the "Previous" button, and a box "Click here, to Move next page" pointing to the "Save & Next" button.

- Bank details to be filled only once or while filling the first claim.
- For Subsequent claims, the fields will be auto populated.
- Please Upload Cancelled cheque.
- Please enter the employee's PAN details if the claim is greater than 1lac.

Step 5: Upload Document

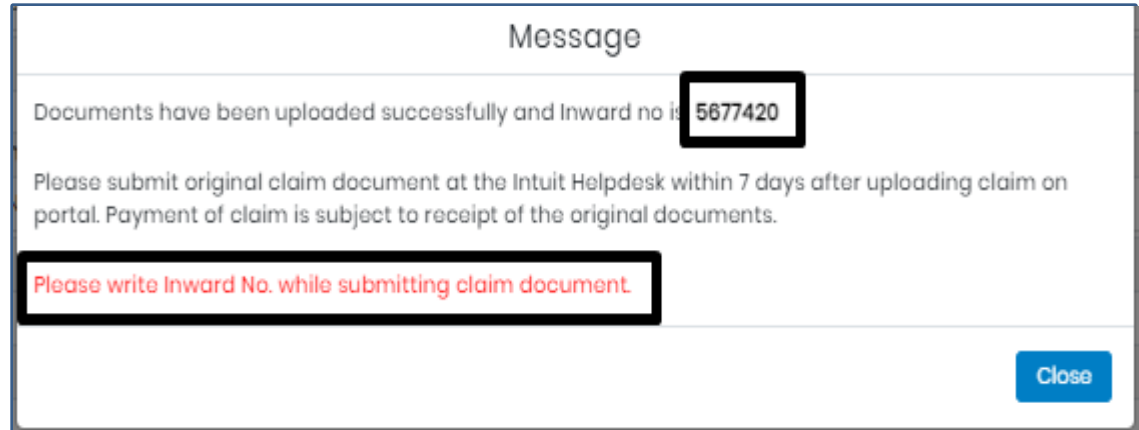
Step 5 :

The screenshot shows the 'Upload Document' section of a web application. At the top, there are five navigation tabs: Patient Details, Disclaimer, Claim Form, Bank Details, and Upload Document. The 'Upload Document' tab is active. Below the tabs, there are instructions: 'Upload pdf/jpg format documents only.' and 'The PDF file should not exceed more than 12 Mb.' A table lists documents with columns for 'Sr. No.', 'Document Name', and actions. Annotations with arrows point to various elements: 'Click here to View Claim form' points to the 'View' button for the first document; 'Click here to View Neft details' points to the 'View' button for the third document; 'Click here to Delete' points to the 'Delete' button for the third document; 'Click here to move to previous page' points to the 'Previous' button; 'Click here to Submit' points to the 'Submit Claim' button; 'Click Arrow button to Upload documents' points to the upload icon in the 'Upload' column; and 'Click here to delete the documents' points to the 'Delete' button in the 'Delete' column.

Sr. No.	Document Name	View	Delete
1	claim Form Name 99023291_CLAIMFORM.pdf	View	Delete
2	KYC DOCUMENTS		
3	NEFT DOCUMENTS Name 99023291_NEFT.JPEG	View	Delete
4	DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY		
5	FINAL HOSPITAL BILL		
6	INVESTIGATION REPORT		
7	MEDICINE PRSCRIPTION		
8	Other		

- ❑ If you have more documents / receipts in claim, to share the claim Number and email Paramount on helpdesk.intuit@paramounttpa.com

- After Clicking the submit tab POP-UP appears.
- Please Use this Inward No. for further correspondence and to track your claim till claim No. is generated.
- It takes 24-48 Hours to generate Claim No.
- In case Claim No. is not generated within 24hrs please write a mail to-
helpdesk.intuit@paramounttpa.com



Claim Submission-Parent in Law Policy

Click Claim Submission to upload the claims

Paramount Health Services & Insurance
RDA License No. 038 (Valid upto 30.03.2023)

HI TEST EMPLOYEE
Logout

Online Enrollment Beneficiary Details & E-card **Claim Submission** Track Claim Details

Hospital Network Claim Procedure Policy Benefits & FAQ Wellness

Contact Us Downloads

Useful Links
Mobile App --
Checklist --
TPA branches --

Dashboard > Claim Submission

GMC policy Claim Submission Covid Policy Claim Submission **Parent In Law Policy** Pre Post Hospitalization Deficiency Claim

Name	Gender	Date of Birth	Age	Relation	Action
Test Father In Law	Male	03-Nov-1945	76	Father In Law	Upload IPD Claim
Test Mother In Law	Female	20-May-1948	74	Mother In Law	Upload IPD Claim

Click here to Upload IPD Claim

Step 1: Patient Details(IPD Claims)

Step 1:

Dashboard > Claim Submission

GMC Policy Claim Submission	Covid Policy Claim Submission	Parent In Law Policy	Pre Post Hospitalization	Deficiency Claim	
Name	Gender	Date of Birth	Age	Relation	Action
Test Father In Law	Male	02-Nov-1945	78	Father In Law	Upload PD Claim
Test Mother In Law	Female	20-May-1948	74	Mother In Law	Upload PD Claim

Click here to Upload IPD Claim

Patient Details

Disclaimer

Claim Form

Bank Details

Upload Document

Patient Details

All fields marked * are mandatory.

Patient Name: TEST EMPLOYEE Date of Birth: 21/07/1982 Age: 39 Gender: MALE

PHS ID: 3963262 TPA Claim No.: 0 TPA Claim Ext.: Relation With Insured: EMPLOYEE

Date Of Admission Date of Discharge

Please select the Date of Admission

Please select the Date of Discharge

Next

Click "Next"

- To upload Hospitalization claim in Covid Policy, Click Upload Hospitalization claim tab.
- Select Date of Admission and Date of Discharge.
- Click “ Next”.

Step 2: Declaration

Step 2:

- After clicking “Next”
- Click Agree& Next, To go for next step.
- Click Print, To Print Self declaration document
- To move to previous page click “Previous’ tab.

To,
Paramount Health Services & Insurance Pvt Ltd.
----- (Branch)

[Self-declaration](#)

I do hereby solemnly affirm and declare as under that:

1. **TEST FATHER IN LAW** , hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy vide No. **8022200502270000739** .
2. I hereby declare that I shall not produce or claim the physical copy of the electronically submitted claim documents submitted to Paramount Health Services & Insurance TPA Pvt Ltd (attached herewith) at any other Insurer/ TPA for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present Insurance policy is not sufficient to cover claim amount fully and I have other Insurance policies to cover balance claim amount from either same or different Insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
3. I shall ensure that a hard copy of claimed hospitalization documents shall be submitted to the Intuit helpdesk within 30 days from the date of uploading the claim file on the portal.
4. I further assure that I shall reimburse or indemnify the Insurance Company for the claim amount in case of a fraudulent, duplicate, forged, and manipulated claim submission or if this self-declaration is found untrue and dishonest.

Sincerely,

Name & Signature of the Claimant

Place -
Date -

Note -

1. This declaration for scanned claim documents submission is Valid till the lock down is lifted.
2. All claim documents shall be self attested and to be submitted along with the signed declaration and self attested Identity Proof.

[Insurer Guidelines](#)
NATIONAL INSURANCE COMPANY LTD.

- The Claim will be processed based on the complete set of scanned documents uploaded by the Insured through the portal. In case of any deficient document/requirement, we may raise the query & process further on receipt of these documents.
- In the meantime, Insured has to submit the Original Claim documents at the nearest Paramount branch
- Insured will not be claiming for the same hospitalization with any other Insurance Company/TPA or anywhere else for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present Insurance policy is not sufficient to cover the claim amount fully and I have other Insurance policies to cover balance claim amount from either same or different Insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
- Intimation of claim should be made to TPA through Email, Call, portal, or mobile app as per the defined timeline.
- All Documents submitted as scanned copies should be self-attested by Insured.

To go to previous step click here ← Previous print Agree & Next ← To go to next step Click Agree_Next

↑
To print the self-declaration Form click here

Step 3: Claim Form –Part-A

Step 3 :

- Please Enter the Employee Name , E-mail id and Phone no.
- Please Enter E-mail id in Details of insured person hospitalized.
- Please Select the name of the hospital where Admitted.

Claim Form

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED

Reimbursement (To be filled in block letters)

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED:

a) Policy No: R0220050220000730
b) SI No/ Certificate No: [Redacted] c) Phs No/ IPA ID No: 3983262

Employee: TEST EMPLOYEE

a) Address: [Redacted]
City: [Redacted] State: [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Please fill the Mandatory fields

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/YYYY
c) If yes, company name: [Redacted] Policy No: R0220050220000730 Sum Insured (rs): [Redacted]
d) Have you been hospitalized in the last four years since inception of the contract? Yes No
Date: M: [Redacted] Y: [Redacted] Diagnosis: [Redacted]
e) Previously covered by any other Mediclaim / Health insurance: Yes No
f) If yes, Company Name: [Redacted]

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: TEST EMPLOYEE
b) Gender: Male Female c) Age: years [Redacted] months [Redacted] d) Date of Birth: 21/07/1982
e) Relationship to Primary insured: Self Spouse Child Other Mother Other
(Please Specify) [Redacted]
f) Occupation: Service Self Employed Homemaker Student Retired Other
(Please Specify) [Redacted]
g) Address (if different from above): [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Fill the Mandatory Fields

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: [Redacted] Search Hospital
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/YYYY
e) Date of Admission: 27/09/2022 f) Time: Hrs: [Redacted] Min: [Redacted] g) Date of Discharge: 30/09/2022 h) Time: Hrs: [Redacted] Min: [Redacted]
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse Alcohol Consumption
i. If Medico legal: Yes No ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No
j) System of Medicine: [Redacted]

Step 3: Claim Form-Part- A

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

Sr no.	Expense	Rs.
i	Pre-hospitalization Expenses	
ii	Hospitalization Expenses	
iii	Post-hospitalization Expenses	
iv	Ambulance Charges	
v	Others (code) <input type="text"/> <input type="text"/> <input type="text"/>	
Total		
vi	Pre-hospitalization period: Days <input type="text"/> <input type="text"/> <input type="text"/>	
vii	Post-hospitalization period: Days <input type="text"/> <input type="text"/> <input type="text"/>	

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

c) Details of Lump sum / cash benefit claimed

Sr no.	Expense	Rs.
i	Hospital Daily Cash	
ii	Surgical Cash	
iii	Critical Illness Benefit	
iv	Convalescence	
v	Pre/Post hospitalization Lump sum benefit	
vi	Others (code) <input type="text"/> <input type="text"/> <input type="text"/>	
Total		

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Pre-hospitalization Bills: Nos	
2		D D M M Y Y		Hospital Main Bill	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Post-hospitalization Bills: Nos	
5		D D M M Y Y		Pharmacy Bills	
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DECLARATION BY THE INSURED:
I hereby declare that the information furnished in the claim form 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 forfeited. I also consent & authorize 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 I will not be making any supplementary claim except the pre/post-hospitalization claim, if any

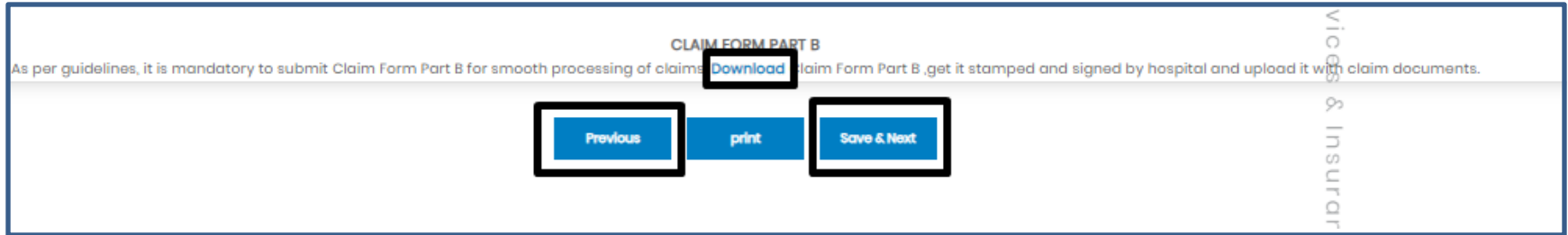
Signature of the Insured

Date

Please Enter the Total Amount →

- Please Enter the Total Amount.
- Enter the Place
- Fill the Signature of Insured.

Step 3: Claim Form –Part B



- Click Download option, to download the Part-B form.
- To go for step 2 Click previous button
- To Take print of claim form ,Click print button
- To go for the next step click Save & Next button

Note: As per Guidelines, It is mandatory to Submit Claim Form part-B for smooth processing. Download the form and get it stamped and signed by Hospital and upload it with claim Documents

Step 4: Bank Details

Step 4 :

The screenshot shows a web form titled "Bank Details". At the top, there is a red instruction: "Please enter the employee's PAN details if the claim amount is greater than 1lac." The form contains several input fields: "Account No." (with a sub-field "Account No."), "Re-enter Account No." (with a sub-field "Re-enter Account No."), "Name as per the Bank Account" (with a sub-field "Name as per the Bank Account"), "IFSC Code" (with a sub-field "IFSC Code"), "Bank Name & Branch" (with a sub-field "Bank Name and Branch"), and "PAN No." (with a sub-field containing "0"). Below these fields is an "Upload Cancelled cheque" section with a "Choose File" button (labeled "No file chosen") and a "View Document" link. At the bottom, there are two blue buttons: "Previous" and "Save & Next". Annotations include a box "Click here to upload cancelled cheque" pointing to the "Choose File" button, a box "To go to pervious page, Click here" pointing to the "Previous" button, and a box "Click here, to Move next page" pointing to the "Save & Next" button.

- Bank details to be filled only once or while filling the first claim.
- For Subsequent claims, the fields will be auto populated.
- Please Upload Cancelled cheque.
- Please enter the employee's PAN details if the claim is greater than 1lac.

Step 5: Upload Document

Step 5 :

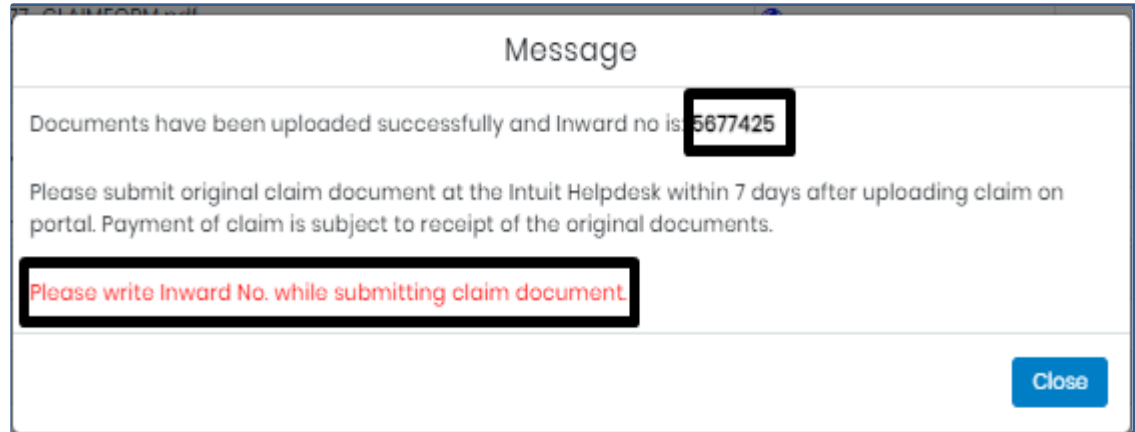
The screenshot shows a multi-step process with five tabs: Patient Details, Disclaimer, Claim Form, Bank Details, and Upload Document. The 'Upload Document' tab is active, displaying a table of uploaded documents. Annotations include: 'Click here to delete the documents' pointing to the top right; 'Click here to View Claim form' pointing to the 'View' button of the first document; 'Click here to View Neft details' pointing to the 'View' button of the third document; 'Click here to Delete' pointing to the 'Delete' button of the third document; 'Click here to Submit' pointing to the 'Submit Claim' button; 'Click Arrow button to Upload documents' pointing to the upload icon in the 'Upload' column; and 'Click here to move to previous page' pointing to the 'Previous' button.

Sr. No.	Document Name	View	Delete
1	claim Form Name 99023291_CLAIMFORM.pdf	View	Delete
2	KYC DOCUMENTS		
3	NEFT DOCUMENTS Name 99023291_NEFT.JPEG	View	Delete
4	DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY		
5	FINAL HOSPITAL BILL		
6	INVESTIGATION REPORT		
7	MEDICINE PRSCRIPTION		
8	Other		

Annotations:

- Click here to delete the documents
- Click here to View Claim form
- Click here to View Neft details
- Click here to Delete
- Click here to Submit
- Click Arrow button to Upload documents
- Click here to move to previous page

- After Clicking the submit tab POP-UP appears.
- Please Use this Inward No. for further correspondence and to track your claim till claim No. is generated.
- It takes 24-48 Hours to generate Claim No.
- In case Claim No. is not generated within 24hrs please write a mail to-
helpdesk.intuit@paramounttpa.com



Claim submission-Pre Post Hospitalization claim

Click Claim Submission to upload the claims

Paramount Health Services & Insurance
RDA License No. 038 (Valid upto 30.03.2023)

HI TEST EMPLOYEE
Logout

Online Enrollment | Beneficiary Details & E-card | Claim Submission | Track Claim Details

Hospital Network | Claim Procedure | Policy Benefits & FAQ | Wellness

Contact Us | Downloads

Useful Links
Mobile App --
Checklist --
TPA branches --

Dashboard > Claim Submission

GMC policy Claim Submission | Covid Policy Claim Submission | Parent In Law Policy | Pre Post Hospitalization | Deficiency Claim


IPD Claim Details

Name	Relation	Intimation No/Date	Inward No/Date	Claim No	Claim Date	Date Of Admission	Claim Type	Claim Sub-Type	Claim Status	Action
Test Employee	Employee	3348723/27-SEP-2022	5568912/20-Aug-2022	5604852/ /0	29-Sep-2022	05-AUG-2022	Reimbursement	Main	Outstanding	Upload Documents
Test Employee	Employee	3348743/29-SEP-2022	5568129/19-Aug-2022	5604875/ /0	29-Sep-2022	11-AUG-2022	Reimbursement	Main	Outstanding	Upload Documents

Click here to Upload Documents

Note: Select the claim no. which you need to upload deficiency documents.

Step 1: Patient Details(IPD Claims)

Step 1: 

Dashboard > Claim Submission

[GMC policy Claim Submission](#) [Covid Policy Claim Submission](#) [Parent In Law Policy](#) [Pre Post Hospitalization](#) [Deficiency Claim](#)

IPD Claim Details

Name	Relation	Intimation No/Date	Inward No/Date	Claim No	Claim Date	Date Of Admission	Claim Type	Claim Sub-Type	Claim Status	Action
Test Employee	Employee	3348723/27-SEP-2022	5568802/20-Aug-2022	5694852/ /0	29-Sep-2022	05-AUG-2022	Reimbursement	Main	Outstanding	Upload Documents
Test Employee	Employee	3348743/26-SEP-2022	5566020/16-Aug-2022	5694675/ /0	29-Sep-2022	1-AUG-2022	Reimbursement	Main	Outstanding	Upload Documents

[Click here to Upload Documents](#)

Step 1: Patient Details

Disclaimer Claim Form Bank Details Upload Document

Patient Details

All fields marked * are mandatory.

Patient Name: TEST EMPLOYEE Date of Birth: 21/07/1982 Age: 39 Gender: MALE

PHS ID: 3963262 TPA Claim No.: 0 TPA Claim Ext.: Relation With Insured: EMPLOYEE

Date Of Admission Date of Discharge [Please select the Date of Discharge](#)

[Please select the Date of Admission](#)

[Next](#) [Click "Next"](#)

- To upload Hospitalization claim in Covid Policy, Click Upload Hospitalization claim tab.
- Select Date of Admission and Date of Discharge.
- Click “ Next”.

Step 2: Declaration

Step 2:

- After clicking “Next”
- Click Agree& Next, To go for next step.
- Click Print, To Print Self declaration document
- To move to previous page click “Previous’ tab.

To,
Paramount Health Services & Insurance Pvt Ltd.
----- (Branch)

[Self-declaration](#)

I do hereby solemnly affirm and declare as under that:

1. **TEST FATHER IN LAW** , hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy vide No. **8022200502270000739** .
2. I hereby declare that I shall not produce or claim the physical copy of the electronically submitted claim documents submitted to Paramount Health Services & Insurance TPA Pvt Ltd (attached herewith) at any other Insurer/ TPA for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present Insurance policy is not sufficient to cover claim amount fully and I have other Insurance policies to cover balance claim amount from either same or different Insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
3. I shall ensure that a hard copy of claimed hospitalization documents shall be submitted to the Intuit helpdesk within 30 days from the date of uploading the claim file on the portal.
4. I further assure that I shall reimburse or indemnify the Insurance Company for the claim amount in case of a fraudulent, duplicate, forged, and manipulated claim submission or if this self-declaration is found untrue and dishonest.

Sincerely,

Name & Signature of the Claimant

Place -
Date -

Note -

1. This declaration for scanned claim documents submission is Valid till the lock down is lifted.
2. All claim documents shall be self attested and to be submitted along with the signed declaration and self attested Identity Proof.

[Insurer Guidelines](#)
NATIONAL INSURANCE COMPANY LTD.

- The Claim will be processed based on the complete set of scanned documents uploaded by the Insured through the portal. In case of any deficient document/requirement, we may raise the query & process further on receipt of these documents.
- In the meantime, Insured has to submit the Original Claim documents at the nearest Paramount branch
- Insured will not be claiming for the same hospitalization with any other Insurance Company/TPA or anywhere else for whatsoever reason except in the case where Sum Insured available (incl. bonus) in the present Insurance policy is not sufficient to cover the claim amount fully and I have other Insurance policies to cover balance claim amount from either same or different Insurer wherein the certified copy of same claim documents will be produced without any mala fide intent to claim the amount twice.
- Intimation of claim should be made to TPA through Email, Call, portal, or mobile app as per the defined timeline.
- All Documents submitted as scanned copies should be self-attested by Insured.

To go to previous step click here ← Previous print Agree & Next ← To go to next step Click Agree_Next

↑
To print the self-declaration Form click here

Step 3: Claim Form –Part-A

Step 3 :

- Please Enter the Employee Name , E-mail id and Phone no.
- Please Enter E-mail id in Details of insured person hospitalized.
- Please Select the name of the hospital where Admitted.

Claim Form

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED

Reimbursement (To be filled in block letters)

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED:

a) Policy No: R0220050220000730
b) SI No/ Certificate No: [Redacted] c) Phs No/ IPA ID No: 3983262

Employee: TEST EMPLOYEE

a) Address: [Redacted]
City: [Redacted] State: [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Please fill the Mandatory fields

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/YYYY
c) If yes, company name: [Redacted] Policy No: R0220050220000730 Sum Insured (rs): [Redacted]
d) Have you been hospitalized in the last four years since inception of the contract? Yes No
Date: M: [Redacted] Y: [Redacted] Diagnosis: [Redacted]
e) Previously covered by any other Mediclaim / Health insurance: Yes No
f) If yes, Company Name: [Redacted]

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: TEST EMPLOYEE
b) Gender: Male Female c) Age: years [Redacted] months [Redacted] d) Date of Birth: 21/07/1982
e) Relationship to Primary insured: Self Spouse Child Other Mother Other
(Please Specify) [Redacted]
f) Occupation: Service Self Employed Homemaker Student Retired Other
(Please Specify) [Redacted]
g) Address (if different from above): [Redacted]
Pin Code: [Redacted] Phone No: 9930368983

Email ID: SHRADDHA.SHARMA@PARAMOUNTTPA.COM

Fill the Mandatory Fields

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: [Redacted] Search Hospital
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/YYYY
e) Date of Admission: 27/09/2022 f) Time: Hrs: [Redacted] Min: [Redacted] g) Date of Discharge: 30/09/2022 h) Time: Hrs: [Redacted] Min: [Redacted]
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse Alcohol Consumption
l. If Medico legal: i. Reported to police: ii. MLC Report & Police FIR attached:
Yes/No Yes/No Yes/No
j) System of Medicine: [Redacted]

Step 3: Claim Form-Part- A

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

Sr no.	Expense	Rs.
i	Pre-hospitalization Expenses	
ii	Hospitalization Expenses	
iii	Post-hospitalization Expenses	
iv	Ambulance Charges	
v	Others (code) <input type="text"/> <input type="text"/> <input type="text"/>	
Total		
vi	Pre-hospitalization period: Days <input type="text"/> <input type="text"/> <input type="text"/>	
vii	Post-hospitalization period: Days <input type="text"/> <input type="text"/> <input type="text"/>	

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

c) Details of Lump sum / cash benefit claimed

Sr no.	Expense	Rs.
i	Hospital Daily Cash	
ii	Surgical Cash	
iii	Critical Illness Benefit	
iv	Convalescence	
v	Pre/Post hospitalization Lump sum benefit	
vi	Others (code) <input type="text"/> <input type="text"/> <input type="text"/>	
Total		

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Pre-hospitalization Bills: Nos	
2		D D M M Y Y		Hospital Main Bill	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Post-hospitalization Bills: Nos	
5		D D M M Y Y		Pharmacy Bills	
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DECLARATION BY THE INSURED:
I hereby declare that the information furnished in the claim form 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 forfeited. I also consent & authorize 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 I will not be making any supplementary claim except the pre/post-hospitalization claim, if any

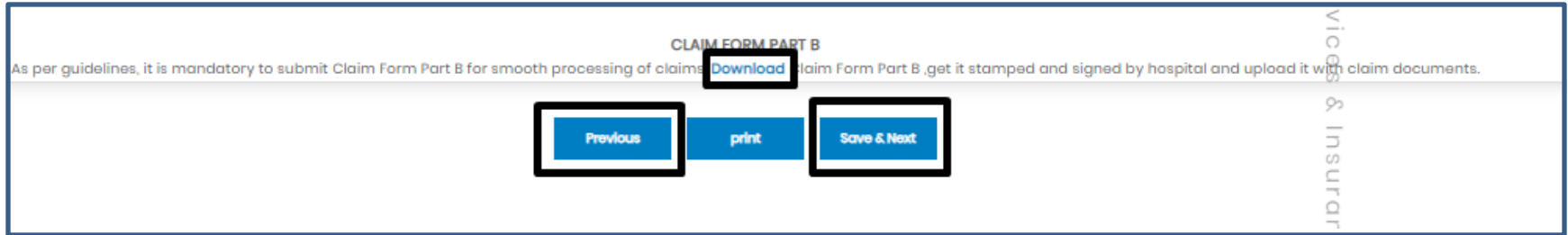
Signature of the Insured

Date

Please Enter the Total Amount →

- Please Enter the Total Amount.
- Enter the Place
- Fill the Signature of Insured.

Step 3: Claim Form –Part B



- Click Download option, to download the Part-B form.
- To go for step 2 Click previous button
- To Take print of claim form ,Click print button
- To go for the next step click Save & Next button

Note: As per Guidelines, It is mandatory to Submit Claim Form part-B for smooth processing. Download the form and get it stamped and signed by Hospital and upload it with claim Documents

Step 4: Bank Details

Step 4 :

The screenshot shows a web form titled "Bank Details". At the top, there is a red instruction: "Please enter the employee's PAN details if the claim amount is greater than 1Lac." The form contains several input fields: "Account No." (with a sub-field "Account No."), "Re-enter Account No." (with a sub-field "Re-enter Account No."), "Name as per the Bank Account" (with a sub-field "Name as per the Bank Account"), "IFSC Code" (with a sub-field "IFSC Code"), "Bank Name & Branch" (with a sub-field "Bank Name and Branch"), and "PAN No." (with a sub-field containing "0"). Below these fields is an "Upload Cancelled cheque" section with a "Choose File" button (labeled "No file chosen") and a "View Document" link. At the bottom, there are two blue buttons: "Previous" and "Save & Next". Annotations include a box "Click here to upload cancelled cheque" pointing to the "Choose File" button, a box "To go to pervious page, Click here" pointing to the "Previous" button, and a box "Click here, to Move next page" pointing to the "Save & Next" button.

- Bank details to be filled only once or while filling the first claim.
- For Subsequent claims, the fields will be auto populated.
- Please Upload Cancelled cheque.
- Please enter the employee's PAN details if the claim is greater than 1lac.

Step 5: Upload Document

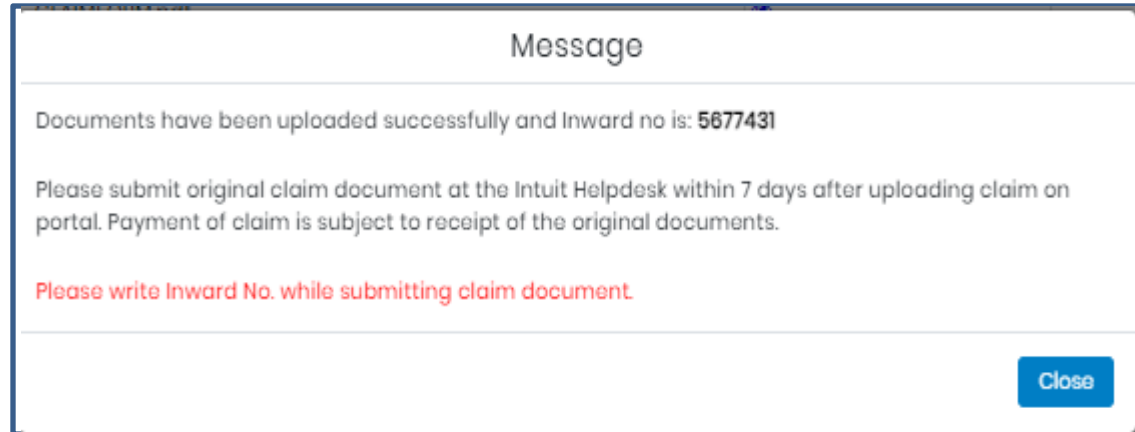
Step 5 :

The screenshot shows the 'Upload Document' section of a web application. At the top, there are navigation tabs: Patient Details, Disclaimer, Claim Form, Bank Details, and Upload Document. The 'Upload Document' tab is active. Below the tabs, there are instructions: 'Upload pdf/jpg format documents only.' and 'The PDF file should not exceed more than 12 Mb.' A table lists documents with columns for 'Sr. No.', 'Document Name', and actions. Annotations with arrows point to various elements: 'Click here to View Claim form' points to the 'View' button for the first document; 'Click here to View Neft details' points to the 'View' button for the third document; 'Click here to Delete' points to the 'Delete' button for the third document; 'Click here to move to previous page' points to the 'Previous' button; 'Click here to Submit' points to the 'Submit Claim' button; 'Click Arrow button to Upload documents' points to the 'Upload' button in the table; and 'Click here to delete the documents' points to the 'Delete' button in the table.

Sr. No.	Document Name	View	Delete
1	claim Form Name 99023291_CLAIMFORM.pdf	View	Delete
2	KYC DOCUMENTS		
3	NEFT DOCUMENTS Name 99023291_NEFT.JPEG	View	Delete
4	DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY		
5	FINAL HOSPITAL BILL		
6	INVESTIGATION REPORT		
7	MEDICINE PRSCRIPTION		
8	Other		

- ❑ If you have more documents / receipts in claim, to share the claim Number and email Paramount on helpdesk.intuit@paramounttpa.com

- After Clicking the submit tab POP-UP appears.
- Please Use this Inward No. for further correspondence and to track your claim till claim No. is generated.
- It takes 24-48 Hours to generate Claim No.
- In case Claim No. is not generated within 24hrs please write a mail to-
helpdesk.intuit@paramounttpa.com



Claim Submission- Deficiency documents

Paramount Health Services & Insurance TPA Pvt. Ltd.
RDA License No. 030 (Valid upto 20.03.2023)

Hi TEST EMPLOYEE Logout

Online Enrollment | Beneficiary Details & E-card | Claim Submission | Track Claim Details

Hospital Network | Claim Procedure | Policy Benefits & FAQ | Wellness

Contact Us | Downloads

Useful Links

- Mobile App --
- Checklist --
- TPA branches --

Dashboard > Claim Submission

GMC policy Claim Submission | Covid Policy Claim Submission | Parent In Law Policy | Pre Post Hospitalization | **Deficiency Claim**

IPD Details

Name	Relation	Intimation No./Date	Inward No./Date	Claim No.	Claim Date	Claim Type	Claim Sub-Type	Claim Status	Action
Test Employee	Employee	3348723/27-SEP-2022	55688012/20-Aug-2022	5694852 /0	29-Sep-2022	Reimbursement	Main	Outstanding	Upload Deficiency Documents
Test Employee	Employee	3348743/29-SEP-2022	5566129/19-Aug-2022	5694875 /0	29-Sep-2022	Reimbursement	Main	Outstanding	Upload Deficiency Documents

OPD Details

Name	Relation	Intimation No./Date	Inward No./Date	Claim No.	Claim Date	Claim Type	Claim Sub-Type	Claim Status	Action
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[Click here to Upload Deficiency Documents](#)