INTUIT Benefits

Reimbursement Claim Procedure

1. Reimbursement claims can be submitted to Paramount Health Services & Insurance TPA Pvt. Ltd. (PHS) through courier, post or in-person at any of our branches.

2. Claim Intimation needs to be given 24-48 hours prior for Planned Hospitalization Or within 24 hours in case of Emergency Hospitalization.

3. Claim form can be collected from the nearest Divisional / Branch Office of the Insurance Company / Paramount office. Claim forms can be downloaded from Paramount portal as well. Issuance of claim form does not amount to admission of any liability, under the policy on the part of the insurers.

4. Claim Documents should be uploaded on Paramount Portal and then can be submitted at the helpdesk set up in Intuit office.6. Within 3-5 working days, the UTR will be generated and the amount will be remitted to the employee.

5. Documents that you need to submit for a hospitalization reimbursement claim should be as per the checklist below:

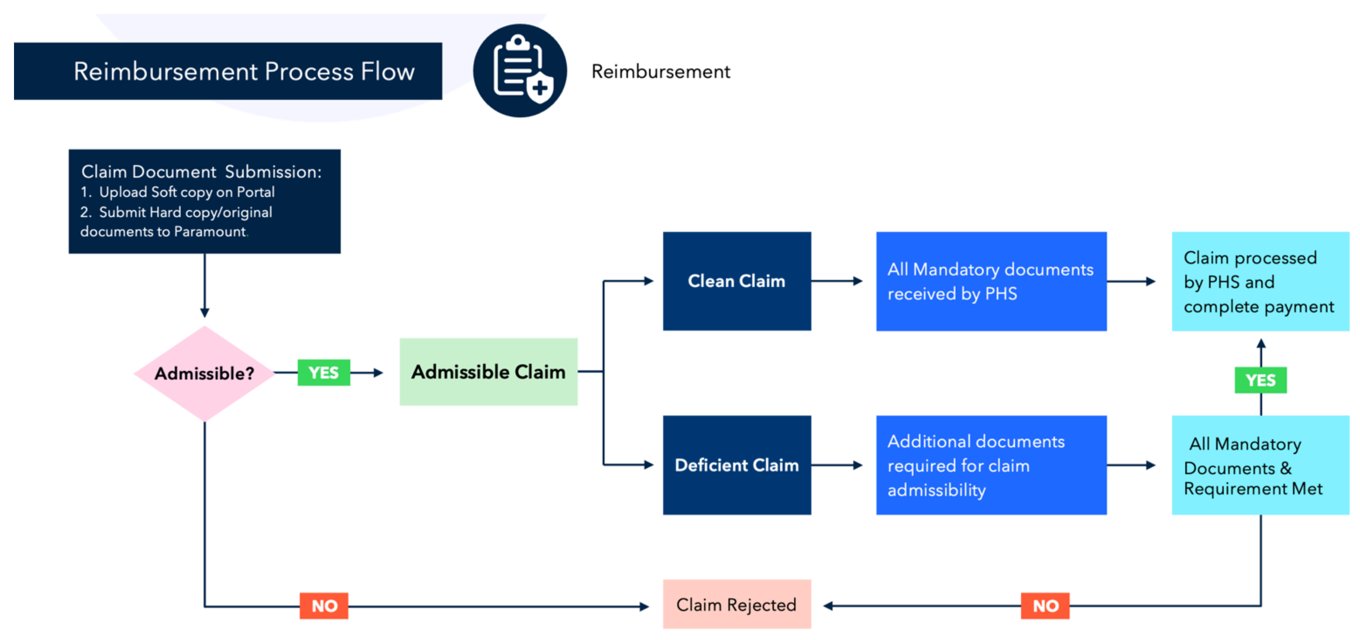
    - IRDA claim form
    - Claim form Part A
    - Claim form Part B
    - Declaration form for PPN/GIPSA hospitals
    - NEFT details / copy of cancelled cheque
    - ID Proof of employee (Any 1 : Passport, voter ID, Driving License or any government approved ID)
    - ID Proof of patient (Any 1 : Passport, voter ID, Driving License or any government approved ID)
    - Original discharge summary / Day care summary / Death summary
    - Original final hospital bill
    - Original payment receipt of main hospital bill

- Receipt of payment made at the hospital by credit card
- Implant invoice Original bills, original payment receipt and investigation / laboratory reports
- Original medicine bill Original copy of first consultation letter

6. On receipt of claim at PHS, your Claim will be scrutinized as per terms and conditions of your health insurance policy. Please note that Non-medical expenses will not be payable.
7. On scrutiny of your Claim if there are any further requirements for ascertaining the Admissibility, we may request for additional information. This additional information is to be submitted within the stipulated time period.
8. On receipt of complete Documents, an appropriate claim decision will be recommended to your respective Insurance Company.
9. On approval of admissible claim, Insurance company will directly credit your/Employer bank account with the net payable amount through NEFT.
10. Upon Rejection of claim, a Repudiation Letter quoting the reason for rejection will be sent to you by the Insurance Company.

Kindly note: If a reimbursement case is reported from a network hospital, it will be settled as per the agreed charges between Insurance Company /TPA and Hospital including discount. Any monies paid over and above the package or agreed rates either to the hospital or the doctor will not be reimbursed.

Reimbursement Process Flow



Cashless Claim Procedure

Cashless facility can be obtained by an active policy holder in a network hospital for that insurance company How to obtain cashless benefit/facility

11. The insured / patient shall confirm the following details pertaining to his/her coverage with regards to: • Policy Service Status • Network Hospital Status • Claim intimation For the above mentioned services you can now use our latest features available like WhatsApp Self Service Bot, Sarthi Chabot, Mobile App 'mW!ise' & Website for real time information.

12. Network Hospital TPA desk assists the insured to apply for cashless benefit.

13. The Hospital TPA desk will submit a fully completed request note from the respective hospital. (Planned hospitalization should be intimated to Paramount at least 72 hours prior to admission. Emergency admission to be intimated within 24 hours after hospitalization)

14. Cashless benefit can be initiated with the submission of Request for Authorization Letter (RAL). As soon as TPA receives the RAL or Preauthorization request form, it will commence to process the request after doing some technical checks within the guided framework of policy terms and conditions.

15. Hospital and the insured will be notified about the progress on the

16. Registered mobile number and email ID provided at the time of cashless request, on a regular basis.

17. Each RAL will be registered under a unique CCN Number and this will form the reference number of all communication pertaining to that particular hospitalization.

18. The RAL will be reviewed and the admissibility will be governed by the policy terms & conditions and ascertained on the basis of medication protocol as well as hospital tariff.

19. After review, if claim is permissible, PHS will issue Authorization Letter (A/L) to the respective network hospital. All amount/s will be authorized as per hospital tariff, package or schedule of charges, mutually agreed upon with either PHS/GIPSA or Private Insurance Companies, whichever is applicable as per policy. Insured should note that the policy may contain certain exclusions &/or restrictions which will be applied at the time of initial & final authorization. Non-medical expenses (NME)are not payable and will be deducted.

20. In case of any deficiency of documents or additional information requirement, PHS will raise a query to the hospital. The query should ideally be replied / resolved within 24 hours. Once revert/reply is received, the claim will be re-processed based on merit.

21. If coverage cannot be established the claim will be declined (denied) for cashless benefit. 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. The insured/patient can submit documents for reconsideration in reimbursement along with claim form, in case claim is denied for cashless.

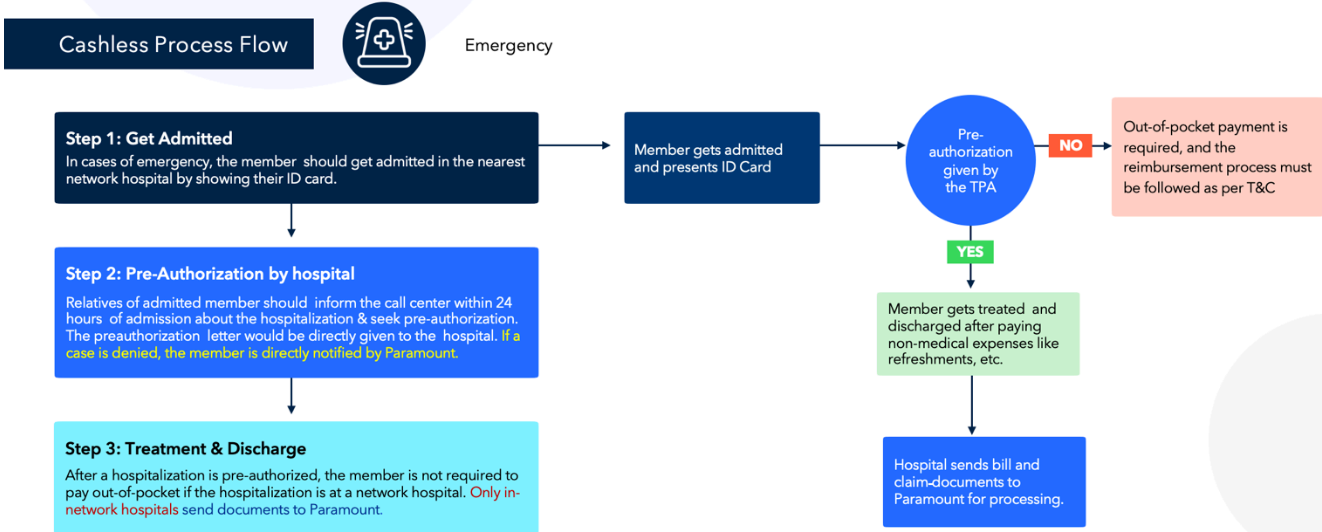
22. Prior to discharge, please verify the Discharge Card & Final Bill. Patient/Insured should sign on the original copies as an acknowledgment.

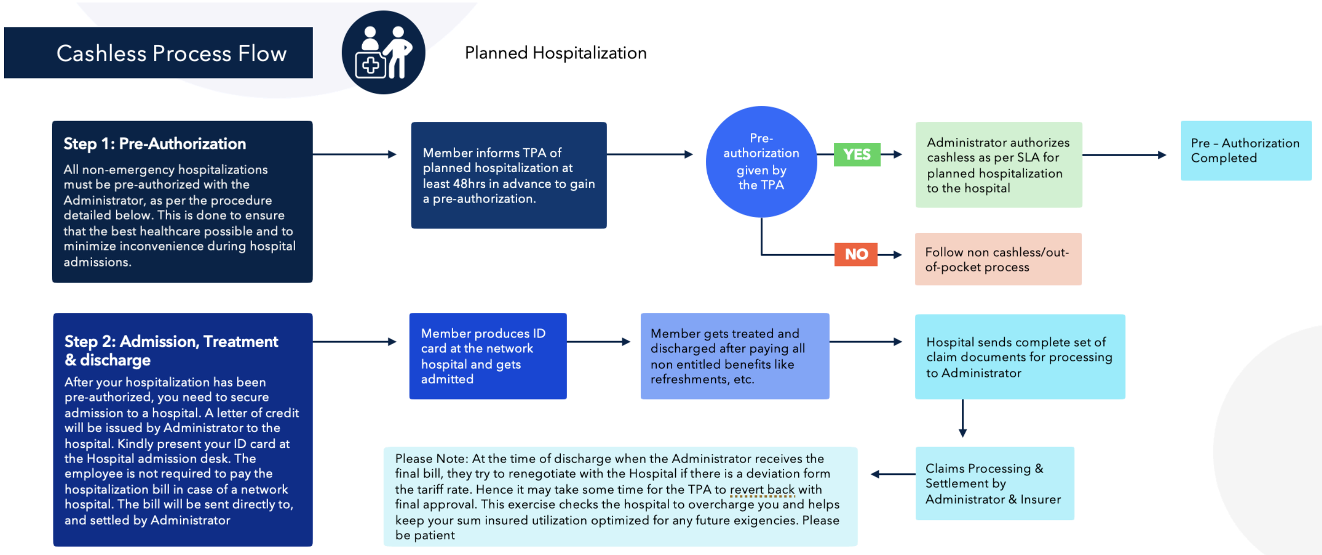
23. In certain instances, insured details may not be available with us. These claims will be registered as Data Not Found (DNF). PHS will follow-up with the respective insurance company & after receiving confirmation from the insurance company the insured data will be updated in the system and the claim will be processed accordingly. In case of corporate policy claims, employees can approach their HR or any other authority as directed by corporate.

24. Hospitals can send the RAL through E-CCN (Portal login) or email it on our dedicated cashless email id available with the network hospital.

25. Documents required for Hassle-free cashless approval and claim settlement

- Duly filled Part C (Request for authorization letter)
- Pre-Hospitalization medical consultation documents, investigations, hospitalization details, OPD notes.
- Patient ID proof along with KYC details (PAN and Address proof) of Employee / Policy Proposer is mandatory at the time of cashless request.
- If the estimated amount is Rs.1 lakh and above, then Pan-card of the policy holder / Employee is mandatory.
- Duly filled CKYC form of the Proposer / Employee should be provided for all claims amounting Rs.1 lakh and above.


Cashless Process Flow
Emergency
Step 1: Get Admitted
In cases of emergency, the member should get admitted in the nearest network hospital by showing their ID card.
Step 2: Pre-Authorization by hospital
Relatives of admitted member should inform the call center within 24 hours of admission about the hospitalization & seek pre-authorization. The preauthorization letter would be directly given to the hospital. If a case is denied, the member is directly notified by Paramount.
Step 3: Treatment & Discharge
After a hospitalization is pre-authorized, the member is not required to pay out-of-pocket if the hospitalization is at a network hospital. Only in-network hospitals send documents to Paramount.
Member gets admitted and presents ID Card
Pre-authorization given by the TPA
NO
Out-of-pocket payment is required, and the reimbursement process must be followed as per T&C
YES
Member gets treated and discharged after paying non-medical expenses like refreshments, etc.
Hospital sends bill and claim-documents to Paramount for processing.


Cashless Process Flow
Planned Hospitalization
Step 1: Pre-Authorization
All non-emergency hospitalizations must be pre-authorized with the Administrator, as per the procedure detailed below. This is done to ensure that the best healthcare possible and to minimize inconvenience during hospital admissions.
Member informs TPA of planned hospitalization at least 48hrs in advance to gain a pre-authorization.
Pre-authorization given by the TPA
YES
Administrator authorizes cashless as per SLA for planned hospitalization to the hospital
Pre - Authorization Completed
NO
Follow non cashless/out-of-pocket process
Step 2: Admission, Treatment & discharge
After your hospitalization has been pre-authorized, you need to secure admission to a hospital. A letter of credit will be issued by Administrator to the hospital. Kindly present your ID card at the Hospital admission desk. The employee is not required to pay the hospitalization bill in case of a network hospital. The bill will be sent directly to, and settled by Administrator
Member produces ID card at the network hospital and gets admitted
Member gets treated and discharged after paying all non entitled benefits like refreshments, etc.
Hospital sends complete set of claim documents for processing to Administrator
Claims Processing & Settlement by Administrator & Insurer
Please Note: At the time of discharge when the Administrator receives the final bill, they try to renegotiate with the Hospital if there is a deviation form the tariff rate. Hence it may take some time for the TPA to revert back with final approval. This exercise checks the hospital to overcharge you and helps keep your sum insured utilization optimized for any future exigencies. Please be patient