



Paramount TPA Portal

Out Patient Domiciliary (OPD), Dental and Vision
Reimbursement - Claims submission guide

OPD, Dental and Vision Reimbursement - Claim Submission Process

Log into [Paramount tool](#) via SSO

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 |
| Contact Us | Downloads | | |

Useful Links

- Mobile App →
- Checklist →
- TPA branches →

Upload OPD/Dental/Vision claims

Click here to submit OPD claims

Paramount Health Services & Insurance TPA Pvt. Ltd.
RGA License No: 006 (Valid upto 30.03.2023)

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 --



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 OPD/Dental/ Vision claims

Please refer to the [Intuit benefits page](#) for details of OPD, Dental and vision reimbursement.

Step 1: Patient Details

Step 1: →

Patient Details

All fields marked * are mandatory.

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

PHS ID : 3963282 TPA Claim No. : 5694652 TPA Claim Ext. : Relation With Insured : EMPLOYEE

Date of Consultation : 29/09/2022

Next Click next


Dashboard > Claim Submission

| 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

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

Step 2: Self Declaration

Step 2 : 

- Click Agree & Next, to go to next step

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

Self-declaration

I do hereby solemnly affirm and declare as under that:

1. **TEST EMPLOYEE**, hereby undertake that I am a Policyholder of **NATIONAL INSURANCE COMPANY LTD.** Insurance company, bearing Insurance Policy vide No. **602200/50/22/0000730**.
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.

[Click here, to download self declaration form](#)

[Click here, to previous page](#) [Previous](#) [Download](#) [Agree & Next](#) [Click here, to move to next step](#)

Step 3: Claim form: Part-A

**OPD CLAIM FORM
PART - A**

Name of Policy Holder/Employee : TEST EMPLOYEE
 Policy Name : 602200/50/22/0000730
 PIS ID : 0003282
 Policy Type : Individual Policy Retail Policy Group Policy Corporate Policy
 Company Name :
 Employee Name : TEST EMPLOYEE Employee ID : 02345

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/Retiree/Other
 Residential Address :
 City : State : Pin Code :
 *Insurance No. : 9930388963 Landline No. :
 E mail id : SHRADDHASHARMA@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 (Pis 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

- Copy of Aadhar Card of employee
- Copy of PAN Card employee

Declaration

I hereby agree, affirm and declare that -

- The statements/information given in this claim form are true correct and complete.
- 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.
- 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.
- 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.
- 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.
- 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.
- I confirm that the expenses for which claim is being lodged have been incurred in respect to the insured.

Date : 20/10/2022 Place : Signature Of Claimant

Click here to go previous step → Previous Download Save & Next ← Click here to move next step
Click here to download Claim form

- Please Enter Mobile No.
- Enter Total Claim amount
- Fill Place & Signature of claimant
- Click "Save & Next"

Step 4: Bank Details

Step 4 : →

Bank Details

Please enter the employee's PAN details if the claim amount is greater than 1Lac.

| | | | | | |
|-------------|----------------------|----------------------|----------------------|------------------------------|--------------------------------|
| Account No. | <input type="text"/> | Re-enter Account No. | <input type="text"/> | Name as per the Bank Account | <input type="text"/> |
| IFSC Code | <input type="text"/> | Bank Name & Branch | <input type="text"/> | PAN No. | <input type="text" value="0"/> |

Upload Cancelled cheque [Click here to upload cancelled cheque](#) No file chosen [View Document](#)

[To go to pervious page, Click here](#) [Click here, to Move next page](#)

- Bank details to be filled only once or while filling the first claim.
- For subsequent claims, the fields will be auto populated.
- Please upload Personalized Cancelled cheque with name mentioned on cheque leaf
- Please enter employee's PAN details if the claim is greater than INR 1 lakh.

Step 5: Upload Document

Step 5 : →

Upload Document

• The PDF file should not exceed more than 12 Mb.

- Upload pdf/jpg format documents only.
- The PDF file should not exceed more than 12 Mb.

| 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 | | |

Click here to move to previous page → Previous Submit Claim

Click here to Submit

Click Arrow button to Upload documents

Click here to Delete

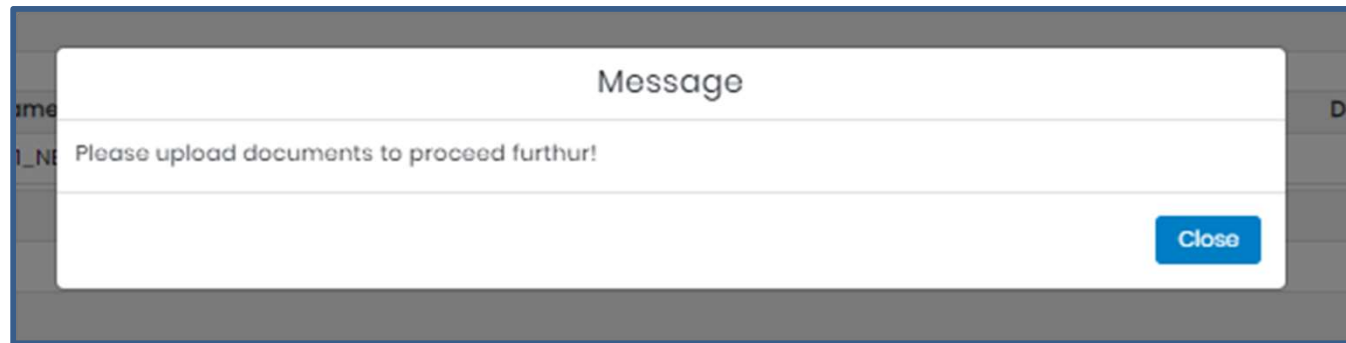
Click here to View Claim form

Click here to View Neft details

Click here to delete the documents

- Each PDF file Should not exceed more than 12Mb.

- In case you miss uploading any mandatory fields / documents under **Step 5** (Upload documents), a pop-up message will appear indicating you to upload documents.



- After uploading documents in respective sections click “Submit claim”

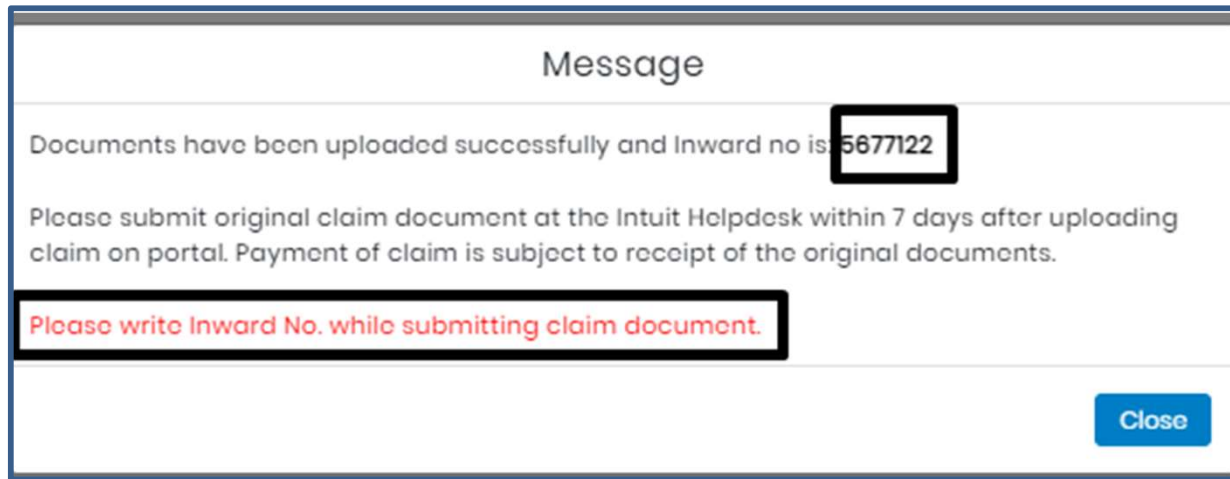
Upload Document

• Upload pdf/jpg format documents only. The PDF file should not exceed more than 12 Mb. Important

| Sr. No. | Document Name | Upload | Delete |
|---------|---|---------------|---------------|
| 1 | claim Form Name: 00022291_CLAIMFORM.pdf View: [icon] Delete: [icon] | [upload icon] | [delete icon] |
| 2 | KYC DOCUMENTS | [upload icon] | [delete icon] |
| 3 | NEFT DOCUMENTS Name: 00022291_NEFT.PDF View: [icon] Delete: [icon] | [upload icon] | [delete icon] |
| 4 | DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY | [upload icon] | [delete icon] |
| 5 | FINAL HOSPITAL BILL | [upload icon] | [delete icon] |
| 6 | INVESTIGATION REPORT | [upload icon] | [delete icon] |
| 7 | MEDICINE PRESCRIPTION | [upload icon] | [delete icon] |
| 8 | Other | [upload icon] | [delete icon] |

Click here to upload the documents in respective buckets

Previous
Submit Claim



- 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.
- You can view your Claims No. under Track Your Claims tab
- In case Claim No. is not generated within 48 hours please write a mail to- helpdesk.intuit@paramounttpa.com

Track your claim:



Dashboard > Track Claim Details

Track Claim Details

GMC Claim Details Covid Claim Details Parent in Law Claim Details

IPD Claim Details IPD Claims Listed here

Click here to Track your Claim for IPD claims

| Name | Gender | Date of Birth | Age | Relation | Inward No | Inward Date | Claim No | Claim Date | Documents | Action |
|---------------|--------|---------------|-----|----------|-----------|-------------|----------|-------------|---------------|------------------|
| Test Employee | Male | 21-Jul-1982 | 39 | Employee | 5715157 | 18-Oct-2022 | 5730484 | 20-Oct-2022 | | Track Your Claim |
| Test Employee | Male | 21-Jul-1982 | 39 | Employee | 5568912 | 20-Aug-2022 | 5694652 | 29-Sep-2022 | | Track Your Claim |
| Test Employee | Male | 21-Jul-1982 | 39 | Employee | 5566129 | 19-Aug-2022 | 5694675 | 29-Sep-2022 | | Track Your Claim |
| Test Employee | Male | 21-Jul-1982 | 39 | Employee | 0 | | | | Add/Edit View | Track Your Claim |
| Test Employee | Male | 21-Jul-1982 | 39 | Employee | 0 | | | | Add/Edit View | Track Your Claim |

Click here to Add/ Edit Submitted documents

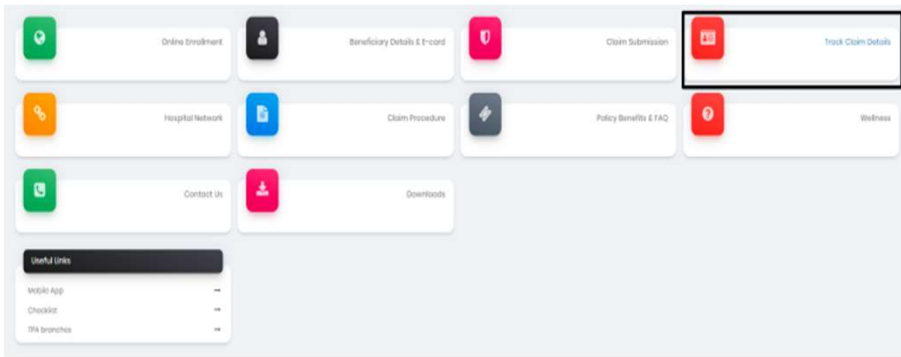
OPD/Dental/Vision Claim Details OPD Claims Listed here

| Name | Relation | Intimation No./Date | Inward No./Date | Claim No. | Claim Date | Claim Type | Claim Sub-Type | Claim Status | Documents | Action |
|---------------|----------|---------------------|----------------------|-----------|-------------|---------------|----------------|--------------|---------------|------------------|
| TEST WIFE | Wife | / | 5716475/ 18-Oct-2022 | 2748843 | 18-Oct-2022 | Reimbursement | Main | Outstanding | | Track Your Claim |
| Test Employee | Employee | / | 5577942/ 24-Aug-2022 | | | | | | Add/Edit View | Track Your Claim |
| Test Employee | Employee | / | 5572579/ 22-Aug-2022 | | | | | | Add/Edit View | Track Your Claim |
| Test Employee | Employee | / | 5572421/ 22-Aug-2022 | | | | | | Add/Edit View | Track Your Claim |

Click here to Track your Claim for OPD claims

Downloading filled in Claim Forms

- Claim Form will be available to download under Track Your Claims tab once the claim no. is generated



| Claim Details | | | | | | | |
|----------------|------------------------|-----------------|---------------------------------|-----------------|---------------------|-----------------------|-------------|
| Inward No.: | 576167 | Inward Date: | 18-oct-2022 | Claim No.: | 5730484 | Claim Date: | 20-oct-2022 |
| Patient Name: | Test Employee | Age: | 39 | Gender: | Male | Relation: | Employee |
| Hospital Name: | Tata Memorial Hospital | State: | Maharashtra | City: | Mumbai | | |
| Pin Code: | 400012 | Insurance Co.: | National Insurance Company Ltd. | | | | |
| Sum Insured: | ₹700000 | Admission Date: | 14-oct-2022 | Discharge Date: | 18-oct-2022 | Hospitalization Days: | 5 |
| Diagnosis: | | Claim Type: | Reimbursement | Claim Status: | Claim File Received | | |
| Bill Amount: | ₹8000 | Settled Amount: | ₹ | | | | |

| | |
|-----------------------------|---|
| Bill Details | + |
| NEFT Details | + |
| SMS Communication Details | + |
| Email Communication Details | + |
| View Documents | + |



Claim Status will be seen here

Click here to View submitted Documents

| View Documents | | | | | | | | | | | |
|----------------|---|---------------|------|---------------|--|---------------|--|---------------|--|---------------|--|
| Sr. No. | Document Name | | | | | | | | | | |
| 1 | CCN COPY | | | | | | | | | | |
| | claim Form | | | | | | | | | | |
| 2 | <table border="1"> <thead> <tr> <th>Document Name</th> <th>View</th> </tr> </thead> <tbody> <tr> <td>5730484_1.pdf</td> <td></td> </tr> <tr> <td>5730484_2.pdf</td> <td></td> </tr> <tr> <td>5730484_3.pdf</td> <td></td> </tr> <tr> <td>5730484_4.pdf</td> <td></td> </tr> </tbody> </table> | Document Name | View | 5730484_1.pdf | | 5730484_2.pdf | | 5730484_3.pdf | | 5730484_4.pdf | |
| Document Name | View | | | | | | | | | | |
| 5730484_1.pdf | | | | | | | | | | | |
| 5730484_2.pdf | | | | | | | | | | | |
| 5730484_3.pdf | | | | | | | | | | | |
| 5730484_4.pdf | | | | | | | | | | | |
| 3 | AL Document | | | | | | | | | | |
| 4 | KYC DOCUMENTS | | | | | | | | | | |
| 5 | NEFT DOCUMENTS | | | | | | | | | | |
| 6 | DELAY INTIMATION / SUBMISSION DOCUMENTS | | | | | | | | | | |
| 7 | DISCHARGE CARD /DEATH SUMMARY /TRANSFER SUMMARY | | | | | | | | | | |

Click here to Download filled in Claim forms



Claims submission and settlement process

1. Claim Number Generation:

Employee submits a claim on Paramount portal, Inward No. is generated followed by a Claim No. (3 to 5 working days)

2. Claims review of soft copy documents by Paramount:

Paramount will review the claims on the portal within 5 to 7 working days of claim no. generation:

a. Documents and receipts submitted are as per policy terms, claims are approved and pending for submission of hard copies.

b. In case shortfall / deficiency documents, Paramount will raise the deficiency request for submission of additional / missing documents (can be submitted via portal).

3. Documents to be submitted:

Employee to submit hard copy of the documents within 1 week of submitting claims on the portal including deficiency documents.

Submit the following documents:

1. Photocopy of consultation and prescription

Note: prescription should be within one year for chronic illness and 90 days for others from the date of consultation. Please reach out to Paramount to get complete list or clarity on this

2. Photocopy of reports and any other medical documents

Note: Tests prescribed by the doctor is only reimbursed

3. Original receipts of the consultation, prescription, test reports and any other medical expenses

4. Submission of hardcopy:

in an envelope with your name, mobile#, Inward No. written on the envelope at the Intuit paramount helpdesk or drop box at building 8, ground floor reception OR

Courier the documents to Paramount office directly to the below address:

Paramount Health Services & Insurance TPA Pvt. Ltd

Janardhan Towers, No.133/23rd Floor,

Residency Road, BANGALORE-560025

Note: *Please ensure INWARD no. is mentioned on the folder/courier cover*

5. Claims approval:

Paramount approves the claims within 7 to 10 working days from the date of hard copy documents submission and sent to insurer for claims settlement.

5. Claims Settlement:

Insurer settles the claims by processing the payment directly to employee's bank account within 7 to 10 working days.

**Please note that the timelines indicated above might take longer incase of holidays / increase in volume of claims*