How to obtain cashless benefit/facility

1. The insured / patient needs to initially confirm the following details pertaining to his/her coverage with regards to:
    - Policy Service Status
    - Network Hospital Status
    - Claim intimation

   All of the above can be confirmed with PHS Call Center or by calling the Helpline number provided on the UHID issued.

   Cashless request note & Hospital network status too can be checked / downloaded from our website www.paramounttpa.com.

2. In certain instances Insured details may not be available. These claims will be registered as Data Not Found (DNF). PHS will follow-up with respective insurance company. After confirmation is received from insurance company the insured data is updated in system & claim will be processed accordingly. In case of corporate claims member can approach their HR.
3. Arrange to submit completely filled request note from respective hospital. Planned hospitalization should be intimated to Paramount atleast 72 hours prior to admission. Emergency admission to be intimated within 24 hours after hospitalization.
4. Request note should be filled completely and duly signed by treating doctor & insured (along with undertaking) with hospital stamp. Mobile number of insured is mandatory.
5. In case of retail policy, policy number and age proof are mandatory. In case of corporate clients, employee ID card or corporate name & employee number is mandatory.
6. Patient ID/Address proof is mandatory as per KYC & AML norms.
7. Prior to admission, consultation, medication papers & investigation reports should be provided alongwith the request.
8. The request has to be faxed or mailed by the hospital to PHS. The insured can confirm receipt of request & further claim status by calling our Call Centre.

   Contact Us:

   Cashless E-mail ID:al.request@paramounttpa.com

   Call Center / Help desk: 022-66620808 (24x7)

   Fax Number: 022-66444709/754/775/755/781 to 784

9. After confirmation of policy, insured & hospital coverage, the request will be registered & a unique Claim Control Number (CCN) will be generated. This number will be exclusively used for all correspondence regarding that particular admission / hospitalization.
10. The claims will be reviewed by claim processor/s. The admissibility will be governed by the policy terms & conditions and ascertained on the basis of medication protocol as well as hospital tariff.
11. 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.
12. In case of any deficiency PHS will raise query to hospital. The query should ideally be resolved within 24 hours. Once revert/reply is received, the claim will be re-processed based on merit (as mentioned in point no.11).
13. 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.
14. Prior to discharge please verify the Discharge Card & Final Bill. Patient/Insured should sign on the original copies as an acknowledgment.

CASHLESS HOSPITALISATION

PLANNED HOSPITALISATION
Submit Pre authorization request to PHS at least 72 hours prior to admission

EMERGENCY HOSPITALISATION
Hospital will submit the pre authorization form to PHS within 24 hrs of admission

Completely filled pre authorization request note along with patient ID proof received at PHS from hospital via email or fax

TPA verifies insured/policy /provider network details, if complete data available then Claim is registered in the system & unique CCN/FIR number is generated.

DNF (Data Not Found) No complete or active data available then all documents sent to insurance company for verification

Verified

TPA verifies pre auth details with policy terms & conditions & sends the response to the hospital

AUTHORIZATION
TPA sends the approval letter to hospital for cashless

DENIAL
TPA rejects the claim under exclusion clause but patient can take treatment & may submit the documents for review in scrutiny.

QUERY
TPA sends query letter to hospital for insufficient documents /information

Response is sent to hospital via mail or fax

*****Auto SMS facility available to insured mobile no. for regular updation of cashless claim status**