ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest ManipalCigna Branch.
Registered & Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com **E-mail:** servicesupport@manipalcigna.com
CIN: U66000MH2012PLC227948
The issue of this Form is not to be taken as an admission of liability
(To be filled in Block Letters) - PART A - To be filled by Insured

ManipalCigna Health Insurance

5 easy ways to speed up the claims process

1. Submit all original documents as per the checklist within 15 days of discharge from the hospital.
2. Make sure the form is complete and don't forget to sign.
3. Provide correct and accurate bank details with Cancelled cheque
4. For any assistance, please reach out to your health advisor or connect with our Health Relationship Manager.
5. Do not conceal or withhold any information with respect to your claim.

MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY CLAIM FORM A

SECTION I- TO BE COMPLETED BY INSURED PERSON/ CLAIMANT

A. DETAILS OF POLICY HOLDER:

a. Name of Corporate/ Group:

b. Master Policy Number: c. Certificate of Insurance Number:

d. Company/ TPA ID No:

e. Name of Policy Holder: FIRST NAME MIDDLE NAME LASTNAME

f. Address:

City: State: Pin Code:

g. Date of Birth: D D M M Y Y Y Y Age: Years Gender: Male Female

h. Occupation:

i. Telephone Number: j. Phone No:

k. Email ID:

B: DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No

b) Date of Commencement of First Insurance without Break: D D M M Y Y Y Y

c) If yes, Company Name:

Policy No.: Sum Insured (₹):

d) Have you been hospitalised in the last four years since inception of the contract? Yes No Date: D D M M Y Y Y Y

Diagnosis:

e) Previously covered by any other Mediclaim / Health Insurance : Yes No

f) If yes, Company Name:

C. DETAILS OF THE INSURED IN RESPECT OF WHOM CLAIM IS MADE (IF OTHER THAN POLICY HOLDER)

a. Name of Insured Person:

b. Member ID of the Insured Person:

c. Date of Birth: D D M M Y Y Y Y d. Occupation: e. Gender: Male Female

f. Telephone Number: g. Phone No:

h. Email ID:

I. Relationship with Policy Holder:

j. Address, if different from above:

D: DETAILS OF HOSPITALIZATION / EVENT:

a) Name and Address of the Hospital:

City: State: Pin Code:

b) Room Category Occupied: Ward Shared room Single Private room Deluxe Suite

Any Other

c) Hospitalisation due to: Injury Illness Maternity

d) Date of Injury / Date Disease first detected / Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y Y Y f) Time: H H : M M

g) Date of Discharge: D D M M Y Y Y Y h) Time: H H : M M

i) If Injury, give Cause: Self Inflicted Road Traffic Accident Substance Abuse Alcohol Consumption

Any Other

a. If Medico Legal: Yes No b. Reported to Police: Yes No c. MLC Report & Police FIR attached: Yes No

j) System of Medicine (Allopathic/ AYUSH):

E. DETAILS OF BENEFITS CLAIMED: (TO BE FILLED BY CLAIMANT AS APPLICABLE)

a. Benefit	Amount (Rs.)
Others: Code	
Total claimed Amount	
Pre-hospitalisation Period: Days	
Post-hospitalisation Period: Days	

Check List of Enclosures for Submission of Claim* (as applicable)

- Original copy of consultations
- Hospital discharge summary in original
- Hospital main bill in original
- Investigation reports, originals of X Ray, MRI, CT films, HPE, ECG
- Pharmacy bills, prescription and invoices
- KYC documents (photo ID proof, address proof, recent passport size photograph)
- Payment receipt.
- Bills from registered service provider (Road Ambulance cover)
- Disability certificate, Fitness certificate, Rest certificate
- Copy of claim intimation, if any
- Claim form duly signed
- Operation Theatre Notes (if applicable)
- Hospital break up bill
- Medical Practitioner's reference slip for investigation
- MLC/ FIR report, post mortem report if applicable and conducted
- Cancelled cheque with name for NEFT payment
- Death summary, death certificate, legal heir certificate if applicable
- Income or salary certificate, ITR
- Other insurer details and claims settlement letter if applicable
- Any additional documents available and related to the case**

** Note that We can call for any additional documents from You pertaining to the claim which can be of support in claim assessment.
*Please refer annexure for additional documents required for claim under any Optional benefits (as applicable).

F. DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued By	Towards	Nos.	Amount (₹)
1.		D D M M Y Y Y Y				
2.		D D M M Y Y Y Y				
3.		D D M M Y Y Y Y				
4.		D D M M Y Y Y Y				
5.		D D M M Y Y Y Y				
6.		D D M M Y Y Y Y				
7.		D D M M Y Y Y Y				
8.		D D M M Y Y Y Y				
9.		D D M M Y Y Y Y				
10.		D D M M Y Y Y Y				
				Total Claimed Amount		

G. PLEASE SUBMIT THE FOLLOWING DOCUMENTS IN CASE CLAIM AMOUNT EXCEEDS RS. 100,000 (AS PER KYC NORMS):

a. Recent passport size photograph (less than six months old).

b. Proof of Identity (Any one of the mentioned documents).
Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter issued by Unique Identification authority of India containing details of name, address and Aadhar number/ Letter from a recognized public authority verifying the identity of the customer.

c. Proof of Residence (Any one of the mentioned documents)
Telephone bill/ Attested current statement of Bank account details/ Letter from any recognized public authority/ Electricity bill provided it is not older than six months from the date of insurance contract / Ration card/ Passport

H. DETAILS OF POLICY HOLDER'S BANK ACCOUNT:

Please furnish the details below along with copy of cancelled cheque.

a) PAN: b) Account Number:

c) Bank Name:

d) Branch Name:

e) IFSC Code: f) MICR Code:

g) Cheque / DD Payable Details:

Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque leaf please attach copy of the first page of the bank passbook also.

I: DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this 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.

Date: D D M M Y Y Y Y Place: Signature of the Insured:

ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
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The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A
(To be filled in block letters) - PART B - To be filled by the Hospital

ManipalCigna Health Insurance

5 easy ways to speed up the claims process

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MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY CLAIM FORM - PART B

SECTION A: DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network (If non network fill section E) ☐

d) Name of the treating doctor: FIRST NAME MIDDLE NAME SURNAME

e) Qualification:

f) Registration No. with State Code: g) Phone No.:

SECTION B: DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: FIRST NAME MIDDLE NAME SURNAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐

d) Age: Years ☐☐ Months ☐☐ e) Date of birth: DD MM YYYY

f) Date of Admission: DD MM YYYY g) Time: HH : MM

h) Date of Discharge: DD MM YYYY I) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

k) If Maternity i. Date of Delivery: DD MM YYYY ii. Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

m) Total claimed amount: ₹

SECTION C: DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description
i. Primary Diagnosis:		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		
b)	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		

iv. Details of Procedure:

SECTION C: DETAILS OF AILMENT DIAGNOSED (PRIMARY)

c) Pre-authorization obtained: Yes ☐ No ☐ d) Pre-authorization No.:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to Injury: Yes ☐ No ☐

i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse ☐ Alcohol consumption ☐

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes ☐ No ☐ (If Yes, attach reports)

iii. If Medico legal: Yes ☐ No ☐ iv. Reported to Police: Yes ☐ No ☐

v. FIR No.: vi. If not reported to police give reason:

SECTION D: CLAIM DOCUMENTS SUBMITTED - CHECK LIST (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

- ☐ Claim Form duly filled and signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes (if applicable)
- ☐ Hospital main bill
- ☐ Hospital break-up Bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E: ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State: Pin Code:

b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of Inpatient beds:

f) Facilities available in the hospital: i. OT : Yes ☐ No ☐ ii. ICU : Yes ☐ No ☐

iii. Others:

SECTION F: DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited

Date: D D M M Y Y Y Y

Place: Signature and Seal of the Hospital Authority: