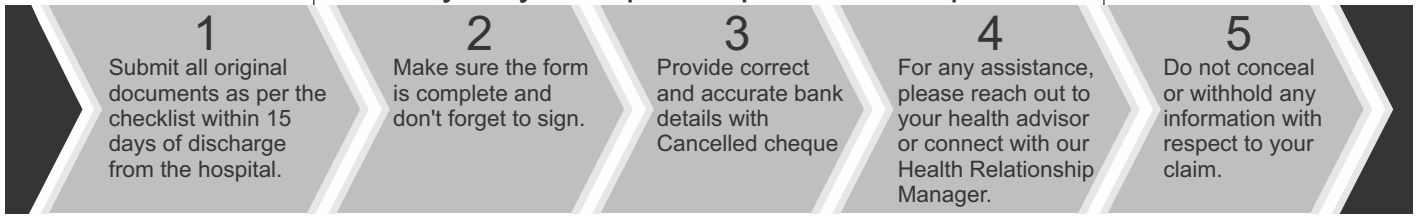


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MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY CLAIM FORM A

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: F I R S T N A M E M I D D L E N A M E L A S T N A M E

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: DD MM YYYY

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

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

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**

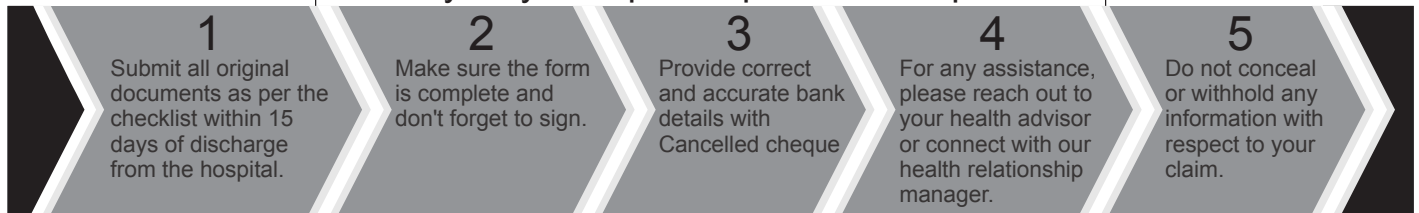
** Note that We can call for any additional documents from You pertaining to the claim which can be of support in claim assessment.
 *Please refer annexure for additional documents required for claim under any Optional benefits (as applicable).

F. DETAILS OF BILLS ENCLOSED:

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

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

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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: F I R S T N A M E M I D D L E N A M E S U R N A M E

e) Qualification:

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

SECTION B: DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: F I R S T N A M E M I D D L E N A M E S U R N A M E

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

d) Age: Years Months e) Date of birth: D D M M Y Y Y Y

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

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

j) Type of Admission: Emergency Planned Day Care Maternity

k) If Maternity i. Date of Delivery: D D M M Y Y Y Y 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:	<input type="text"/>	
ii. Additional Diagnosis:	<input type="text"/>	
iii. Co-morbidities:	<input type="text"/>	
iv. Co-morbidities:	<input type="text"/>	
b)	ICD 10 PCS	Description
i. Procedure 1:	<input type="text"/>	
ii. Procedure 2:	<input type="text"/>	
iii. Procedure 3:	<input type="text"/>	
iv. Details of Procedure:	<input type="text"/>	

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)

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

Place: Signature and Seal of the Hospital Authority: