ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
CIN U66000MH2012PLC227948 | IRDAI Reg. No. 151 Reg. Office: 401/402, 4th Floor, Raheja Titanium, off. Western Express Highway, Goregaon (East), Mumbai- 400 063 | Toll free number – 1800-102-4462
Website address-www.manipalcigna.com | E-mail: servicesupport@manipalcigna.com

ManipalCigna Health Insurance

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY
PART - C (Revised)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER/HOSPITAL:

TO BE FILLED IN BLOCK LETTERS

a) Name of Insurance Company: ManipalCigna Health Insurance Company Limited
b) Toll Free Phone Number: 1800-102-4462
c) Toll free fax:
d) Name of Hospital:
i) Address:
ii) Rohini ID:
iii) Email ID:

TO BE FILLED BY THE INSURED / PATIENT:

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME
b) Gender: Male Female Third Gender c) Age: Years Months d)Date of Birth: DD MM YYYY
e) Contact Number: f) Contact Number of Attending Relative:
g) Insured Card ID Number:
h) Policy Number / Name of Corporate: i) Employee ID:
j) Currently do you have any other Mediclaim / Health Insurance: Yes No
Company Name:
Give Details:
k) Do you have a Family Physician: Yes No l) Name of the Family Physician:
m) Contact Number, if any: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)
n)Current address of Insured Patient:
o)Occupation of Insured Patient:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL:

a) Name of the Treating Doctor:
b) Contact Number:
c) Nature of Illness / Disease with Presenting Complaints:
d) Relevant Critical Findings:
e) Duration of the Present Ailment: Days i. Date of First Consultation: DD MM YYYY
ii. Past History of Present Ailment, if any:
f) Provisional Diagnosis:
i. ICD 10 Code:
g) Proposed Line of Treatment : Medical Management Surgical Management Intensive Care
Investigation Non Allopathic Treatment
h) If Investigation and / or Medical Management, provide details:
i) Route of Drug Administration:
i) If Surgical, name of Surgery: i. ICD 10 PCS Code:
j) If other Treatments, provide details:
k) How did Injury Occur?:
l) In case of Accident:
i. Is it RTA?: Yes No
ii. Date of Injury: DD MM YYYY
iii. Reported to Police: Yes No
iv. FIR No.:
v. Injury / Disease caused due to Substance Abuse / Alcohol Consumption: Yes No
vi. Test conducted to establish this: Yes No (If Yes, attach reports)

m) In case of Maternity: G ☐ P ☐ L ☐ A ☐ Expected date of delivery: D D M M Y Y Y Y

DETAILS OF THE PATIENT ADMITTED :

a) Date of Admission: D D M M Y Y Y Y b) Time of admission: H H M M

c) Is this an Emergency / a Planned Hospitalisation Event?: Emergency ☐ Planned ☐

Mandatory: Past History of any Chronic Illness, if yes (since month / year)

☐ Diabetes:	M M Y Y Y Y	☐ Heart Disease:	M M Y Y Y Y
☐ Hypertension:	M M Y Y Y Y	☐ Hyperlipidemias:	M M Y Y Y Y
☐ Osteoarthritis:	M M Y Y Y Y	☐ Asthma / COPD / Bronchitis:	M M Y Y Y Y
☐ Cancer:	M M Y Y Y Y	☐ Alcohol or Drug Abuse:	M M Y Y Y Y
☐ Any HIV or STD / Related Ailments:	M M Y Y Y Y		

Any other Aliment, give details:

e) Expected No. of Days Stay in Hospital: Days

f) Days in ICU: Days

g) Room Type:

h) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: ₹

I) Expected Cost for Investigation + Diagnostics: ₹

j) ICU Charges: ₹

k) OT Charges: ₹

l) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges: ₹

m) Medicines + Consumables + Cost of Implants (if applicable, please specify) ₹

n) Other hospital expenses if any ₹

o) All Inclusive Package Charges, if any applicable: ₹

p) Sum Total Expected Cost of Hospitalisation: ₹

DECLARATION: (Please read very carefully)

We confirm having read, understood and agreed to the Declarations portion of this form.

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

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

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

DECLARATION BY THE PATIENT / REPRESENTATIVE:

1. I agree to allow the hospital to submit all original documents pertaining to hospitalisation to the Insurer / TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the Terms and Conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the Terms and Conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalisation and the amounts over & above the limit authorised by the Insurer / TPA not governed by the Terms and Conditions of the policy will be paid by me.
4. I hereby declare to abide by the Terms and Conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim and agree to indemnify the Insurer / TPA.
5. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
8. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".
9. I/we hereby give my/our consent to the Company/its authorized representatives to access/download/verify/register/update my/our KYC documents on/from the Central KYC Registry or through any other modes for the purpose of KYC.

a) Patient's / Insured's Name: S U R N A M E F I R S T N A M E M I D D L E N A M E

b) Contact Number: c) Patient's / Insured's Signature: _____

Email ID (optional) :

Date :

Time :

HOSPITAL DECLARATION:

1. We have no objection to any authorised TPA / Insurance Company official verifying documents pertaining to hospitalisation.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. We agree that tpa / insurance company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
4. The patient declaration has been signed by the patient or by his representative in our presence.
5. We agree to provide clarifications for the queries raised regarding this hospitalisation and we take the sole responsibility for any delay in offering clarifications.
6. We will abide by the Terms and Conditions agreed in the MOU.
7. We confirm that no additional amount would be collected liom the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).
8. We confirm that no recoveries would be made from the deposit amount collected from the lnsured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
9. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates,the adhorized TPA / Insurance Company reserves the right to recoverthe same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws.

Hospital Seal

Doctor’s Signature

Date :

Time :

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital, duly signed by the Patient/Representative.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Diagnostic Tests Reports and Receipts supported by note from the attending Medical Practitioner/Surgeon recommending such Diagnostic Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon giving the patient's condition and advice on discharge.

ManipalCigna Sarvah | Request For Cashless Hospitalisation | UIN: MCIHLIP25035V012425 | March 2025