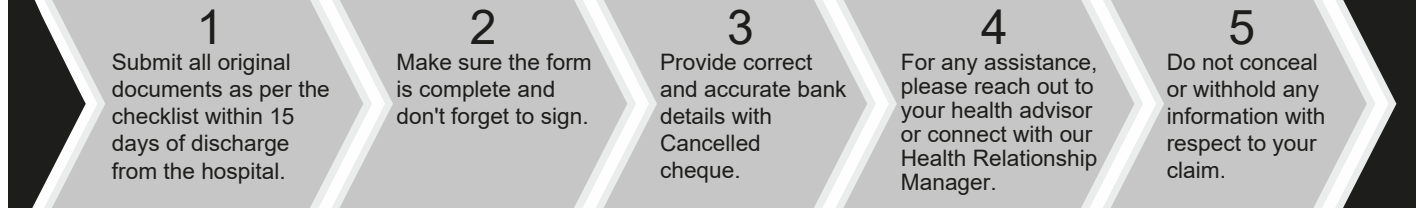


The issue of this Form is not to be taken as an admission of liability
 Please include the original pre-authorisation request form in lieu of PART A. (To be filled in Block Letters)

5 easy ways to speed up the claims process



**MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY
 CLAIM FORM - PART B**

(To be filled by the Hospital)

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:

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 Others

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"/>	<input type="text"/>
ii. Additional Diagnosis:	<input type="text"/>	<input type="text"/>
iii. Co-morbidities:	<input type="text"/>	<input type="text"/>
iv. Co-morbidities:	<input type="text"/>	<input type="text"/>
b)	ICD 10 PCS	Description
i. Procedure 1:	<input type="text"/>	<input type="text"/>
ii. Procedure 2:	<input type="text"/>	<input type="text"/>
iii. Procedure 3:	<input type="text"/>	<input type="text"/>
iv. Procedure 4:	<input type="text"/>	<input type="text"/>

SECTION C: DETAILS OF AILMENT DIAGNOSED (PRIMARY)

c) Pre-authorisation obtained: Yes No d) Pre-authorisation No.:

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

f) Hospitalisation 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-authorisation request	<input type="checkbox"/> CT/MR/USG/HPE investigation reports
<input type="checkbox"/> Copy of the Pre-authorisation 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	<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 _____
<input type="checkbox"/> In case of base claim with some other insurer, please submit insurer or TPA attested copies of documents	

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:

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female or others
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorisation obtained	Indicate whether pre-authorisation obtained	Tick Yes or No
d) Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA
e) If authorisation by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorisation number	Open text
f) Hospitalisation due to injury	Indicate if hospitalisation is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text

SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST

Indicate which supporting documents are submitted

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify

SECTION F - DECLARATION BY THE HOSPITAL

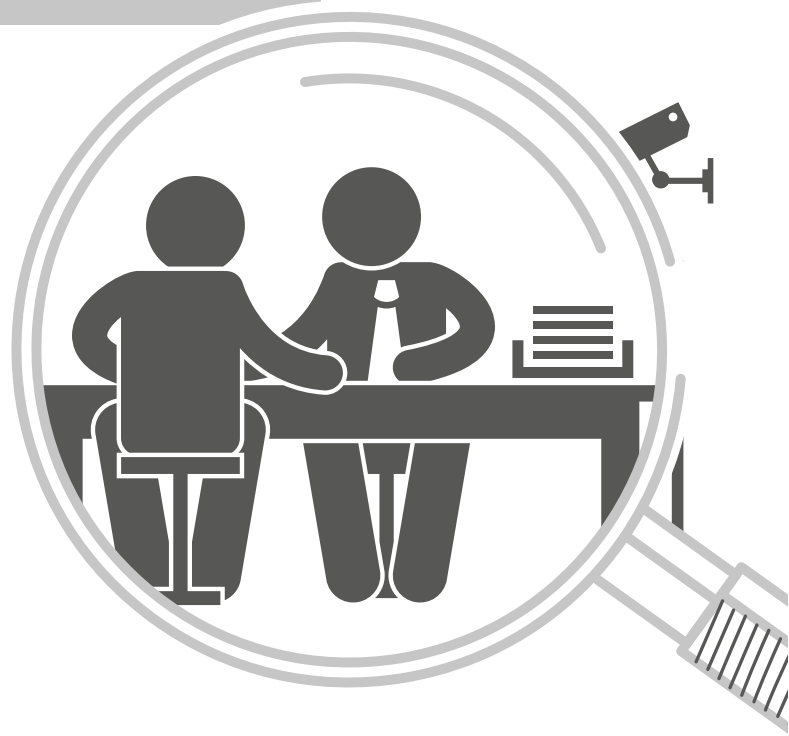
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp

Know Your Customer

Processing your claim smoothly and quickly is of importance to you as well as us. Help us remain as your trusted service partner by ensuring we have a copy of all your documents.

Mandatory KYC documents required

- Original Cancelled cheque
- For claims over 1 lakh
 - Color passport size photograph not older than 6 months
 - Copy of PAN card
 - Copy of address proof



Proof of Residence (Any one of below mentioned documents required)

- Driving license / Adhaar card
- Electricity bill / Ration card*
- Letter from any recognised public authority
- Current statement of bank account with details of permanent/ present residence address as stamped by bank*
- Current passbook with details of permanent/ present residence address (updated up to the previous month)*
- Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof
- Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract
- Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

*Acceptable as Address proof and Identity proof if photograph of applicant is affixed