ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East),
Mumbai – 400063. IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4461
Visit: www.manipalcigna.com **E-mail:** servicesupport@manipalcigna.com

ManipalCigna Health Insurance

REQUEST FOR CASHLESS OUT-PATIENT BENEFIT

(To be filled in block letters)

DETAILS OF HOSPITAL / CLINIC

a. Name of the hospital / Clinic: _____
   i. Address: _____
   ii. Rohini ID: _____
   iii. E-mail ID: _____

TO BE FILLED BY THE INSURED / PATIENT

a. Proposer Name: _____
b. Name of the Patient: _____
c. Gender (Male/ Female/ Third gender): _____
d. Age Years: _____ Month _____
e. Date of birth: _____
f. Contact Number: _____
g. Insured Card ID Number: _____
h. Policy Number: _____
i. Currently do you have any other Mediclaim / Health Insurance: ☐ Yes/ ☐ No
   Company Name: _____
   Give Details: _____
j. Do you have a Family Physician: ☐ Yes/ ☐ No
k. Name of the Family Physician: _____
l. Contact Number, if any: _____
m. Current address of Insured Patient: _____
n. 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 Consultation: _____
   ii. Past History of Present Ailment, if any: _____
f. Provisional Diagnosis: _____
   i. ICD 10 Code: _____

DETAILS OF THE PATIENT

a. Date of Consultation:

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

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

Any other Aliment, give details: _____

b. Consultation charges: _____
c. Cost of investigation: _____
d. Cost of Medicines: _____
e. Total Claimed amount: _____

ManipalCigna ProHealth Prime | Claim Form | Outpatient Expenses | UIN: MCIHLIP26036V022526 | May 2025

DECLARATION

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

a) Name of the Treating Doctor: _____

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 my treatment to the Insurer / TPA.
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 Treatment and the amounts over & above the limit authorized 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".
   a) Patient's / Insured's Name: _____
   b) Contact Number: _____

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.

Email ID (optional): _____

Date: _____

Time: _____

Patient's / Insured's Signature

HOSPITAL DECLARATION

1. We have no objection to any authorised TPA / Insurance Company official verifying documents pertaining to treatment.
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 consultation.
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.

Hospital Seal
(Must include Hospital ID)

Patient / Insured
Name & Signature

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

1. Duly filled and signed claim form
2. Outpatient Invoices
3. Treating Doctor Prescription/Consultation papers
4. Investigation reports and bills, if any
5. Medicine bills