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 REIMBURSEMENT HEALTH MAINTENANCE 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: m m y y y y
☐ Hypertension: m m y y y y
☐ Osteoarthritis: m m y y y y
☐ Cancer: m m y y y y
☐ Any HIV or STD / Related Ailments: m m y y y y
☐ Heart Disease: m m y y y y
☐ Hyperlipidemias: m m y y y y
☐ Asthma / COPD / Bronchitis: m m y y y y
☐ Alcohol or Drug Abuse: m m y y y y

Any other Aliment, give details: _____

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

ManipalCigna ProHealth Select | Claim Form | Health Maintenance Benefit | UIN: MCIHLIP26037V052526 | July 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 hereby declare that the information furnished in the 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.
2. 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.
3. 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.
4. 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.
5. "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: _____
6. I/we hereby give my/our consent to the Company/its authorized representatives to access/download/verify/register/update my/our KYC documents on/fromthe Central KYC Registry or through any other modes for the purpose of KYC

Patient's / Insured's Signature

Email ID (optional): _____

Date: _____

Time: _____

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