ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest Cigna TTK Branch.
401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063. IRDAI Registration No. 151.
Call (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com **E-mail:** customercare@manipalcigna.com **CIN:** U66000MH2012PLC227948

ManipalCigna Health Insurance

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

5 easy ways to speed up the claims process

1. Submit all original documents as per the checklist within 15 days of discharge from the hospital.
2. Make sure the form is complete and don't forget to sign.
3. Provide correct and accurate bank details with Cancelled cheque
4. For any assistance, please reach out to your health advisor or connect with our health relationship manager.
5. Do not conceal or withhold any information with respect to your claim.

MANIPALCIGNA PROHEALTH SELECT 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: FIRST NAME MIDDLE NAME SURNAME

e) Qualification:

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

SECTION B: DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: FIRST NAME MIDDLE NAME SURNAME

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

d) Age: Years Months e) Date of birth: DD MM YYYY

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

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

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

k) If Maternity i. Date of Delivery: DD MM YYYY 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:		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		
b)	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

ManipalCigna ProHealth Select | UIN: MCIHLIP24016V032324 | May 2023

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)

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

Place: Signature and Seal of the Hospital Authority:

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

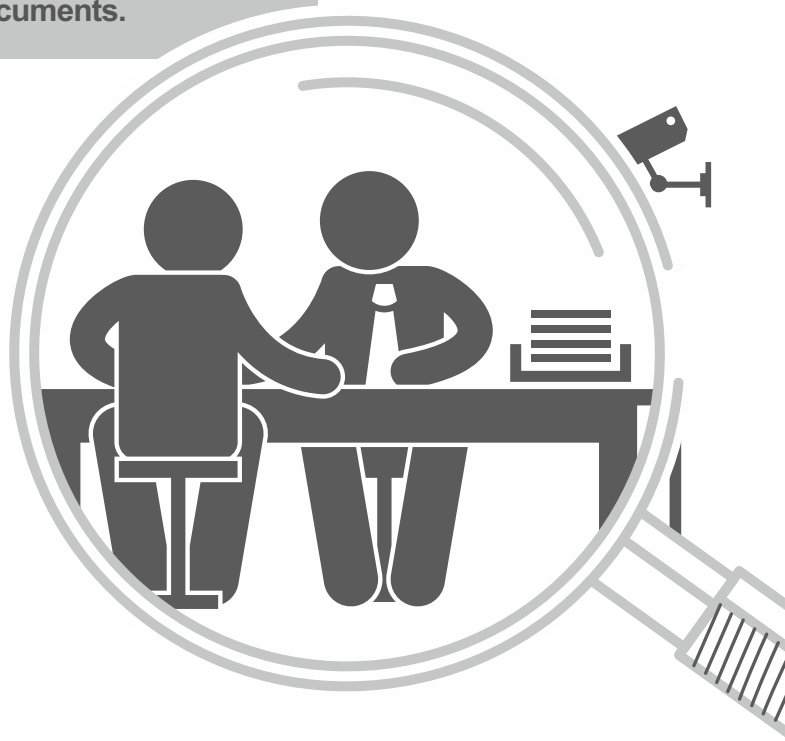
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non-network hospital	Tick the right option
d) 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-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization 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		

ManipalCigna Health Insurance

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.



ID proof (Any one of below mentioned documents required)

- Passport*
- PAN Card
- Voter's Identity card
- Driving license
- Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number
- Job card issued by NREGA duly signed by an officer of the State Government
- Color passport size photograph not older than 6 months

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

- Electricity bill / Ration card*
- Letter from any recognized 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

Request you to provide declaration for crediting claim amount in your (proposer) account provided during policy issuance. **YES** ☐ **NO** ☐

We shall use below mentioned information from the policy for payment of your claim:

• Account Number • Bank Name • Payee Name • IFSC code • Branch Name

ManipalCigna ProHealth Select | UIN: MCIHLIP24016V032324 | May 2023