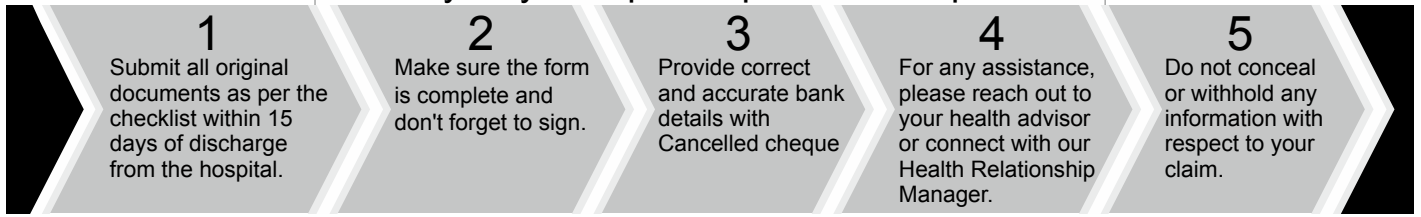


## 5 easy ways to speed up the claims process



### MANIPALCIGNA PROHEALTH INSURANCE POLICY CLAIM FORM A

#### SECTION I- TO BE COMPLETED BY INSURED PERSON/ CLAIMANT

##### A. DETAILS OF PRIMARY INSURED:

a. Policy Number:

b. Sl. No/Certificate No:

c. Company/ TPA ID No

d. Name:  FIRST  NAME  MIDDLE  NAME  LAST  NAME

e. Address:

City:  State:  Pin Code:

Phone No:  Email ID:

##### B: DETAILS OF INSURANCE HISTORY:

a) Currently covered by any Medclaim / Health Insurance: Yes  No

b) Date of Commencement of First Insurance without Break:  DD  MM  YY  YY

c) If yes, Company Name:

Policy No.:  Sum Insured (₹):

d) Have you been hospitalised in the last four years since inception of the contract? Yes  No

Diagnosis:

e) Previously covered by any other Medclaim / Health Insurance : Yes  No

f) If yes, Company Name:

##### C. DETAILS OF INSURED PERSON HOSPITALISED:

a. Name:

b. Gender: Male  Female

c. Age:  Years  Months d. Date of Birth  DD  MM  YY  YY

e. Relationship to Primary Insured:  Self  Spouse  Child  Father  Mother  Other (Please specify)

f. Occupation:  Service  Self Employed  Homemaker  Student  Retired  Other (Please specify)

g. Address(If different from above):

City:  State:  Pin Code:

Phone No:  Email ID:

### D: DETAILS OF HOSPITALISATION:

a) Name of the Hospital where admitted:

City:  State:  Pin Code:

b) Room Category Occupied:  Day care  Single occupancy  Twin sharing  3 or more beds per room

c) Hospitalisation due to:  Injury  Illness  Maternity

d) Date of Injury / Date Disease first detected / Date of Delivery:

e) Date of Admission:           f) Time:   :

g) Date of Discharge:           h) Time:   :

i) If Injury, give Cause:  Self Inflicted  Road Traffic Accident  Substance abuse/Alcohol Consumption

a. If Medico Legal: Yes  No  b. Reported to Police: Yes  No  c. MLC Report & Police FIR attached: Yes  No

j) System of Medicine (Allopathic/ AYUSH):

### E. DETAILS OF CLAIM:

<b>a. Details of Treatment Expenses Claimed:</b>		<b>Amount (Rs.)</b>	
i. Pre-Hospitalisation Expenses:	<input type="text"/>	<input type="text"/>	
ii. Hospitalisation Expenses:	<input type="text"/>	<input type="text"/>	
iii. Post-Hospitalisation Expenses:	<input type="text"/>	<input type="text"/>	
iv. Health Check up Cost:	<input type="text"/>	<input type="text"/>	
v. Ambulance Charges:	<input type="text"/>	<input type="text"/>	
vi. Others:	<input type="text"/>	<input type="text"/>	
<b>Total:</b>	<input type="text"/>	<input type="text"/>	
vii. Pre-Hospitalisation Period: Days	<input type="text"/>	<input type="text"/>	
viii. Post-Hospitalisation Period: Days	<input type="text"/>	<input type="text"/>	

<b>b. Claim for Domiciliary Hospitalisation:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>c. Details of Lump sum/ Cash Benefit Claimed:</b>
i. Hospital Daily Cash: <input type="text"/>
ii. Surgical Cash: <input type="text"/>
iii. Critical illness Benefit: <input type="text"/>
iv. Convalescence: <input type="text"/>
v. Pre/Post-Hospitalisation Lump sum Benefit: <input type="text"/>
vi. Others: <input type="text"/>
<b>Total:</b> <input type="text"/>

<b>Claim Documents Submitted Check List:</b>	
Claim Form Duly Signed	<input type="checkbox"/>
Copy of the Claim Intimation, if any	<input type="checkbox"/>
Hospital Main Bill	<input type="checkbox"/>
Hospital Break up Bill	<input type="checkbox"/>
Hospital Bill Payment Receipt	<input type="checkbox"/>
Hospital Discharge Summary	<input type="checkbox"/>

Pharmacy Bill	<input type="checkbox"/>
Operation Theatre Notes	<input type="checkbox"/>
ECG	<input type="checkbox"/>
Doctor's request for Investigation	<input type="checkbox"/>
Investigation Reports (Including CT/MRI/USG/HPE)	<input type="checkbox"/>
Doctors Prescriptions	<input type="checkbox"/>
Others	<input type="checkbox"/>

### F. DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued By	Towards	Nos.	Amount (₹)
1.		<input type="text"/>		Hospital Main Bill		
2.		<input type="text"/>		Pre-hospitalisation Bills:	Nos	
3.		<input type="text"/>		Post-hospitalisation Bills:	Nos	
4.		<input type="text"/>		Pharmacy Bills		
5.		<input type="text"/>				
6.		<input type="text"/>				
7.		<input type="text"/>				
8.		<input type="text"/>				
9.		<input type="text"/>				
10.		<input type="text"/>				
				<b>Total Claimed Amount</b>		

**G. DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:**

a) PAN:

b) Account Number:

c) Bank name and Branch:

d) Cheque/DD Payable Details:

e) IFSC Code:

Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque leaf please attach copy of the first page of the bank passbook also.

**H: DECLARATION BY INSURED:**

I hereby declare that the information furnished in this 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. 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. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalisation claim, if any.

Date:         Place:  Signature of the Insured:

**GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)**

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organisation
	Enter the TPA ID No	License number as allotted by IRDAI and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organisation in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
Date	Enter the date of hospitalisation	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organisation in full
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALISED</b>		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALISATION</b>		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option

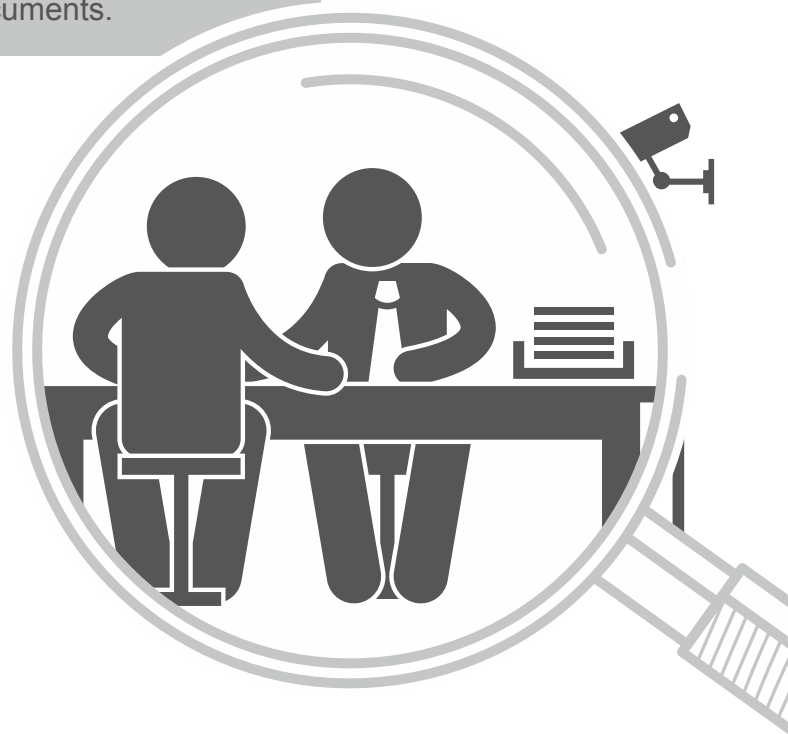
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
<b>SECTION E - DETAILS OF CLAIM</b>		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amounts in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organisation in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

# 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)

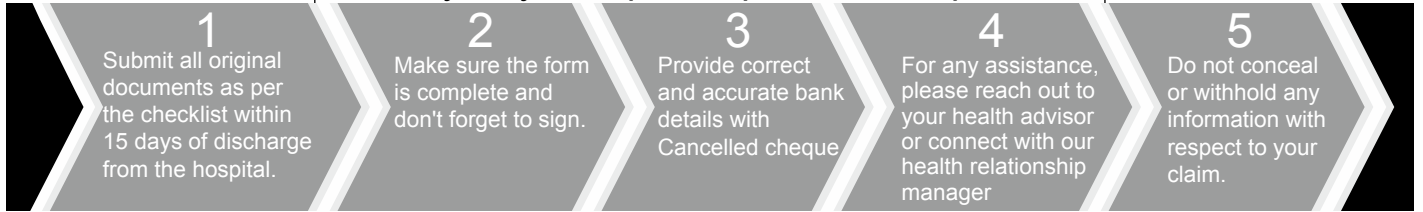
\*Acceptable as Address proof and Identity proof if photograph of applicant is affixed

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

### 5 easy ways to speed up the claims process



## MANIPALCIGNA HEALTH INSURANCE COMPANY LTD. 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:  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

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

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"/>

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

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
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
<b>SECTION B – DETAILS OF THE PATIENT ADMITTED</b>		
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
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)
<b>SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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
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**

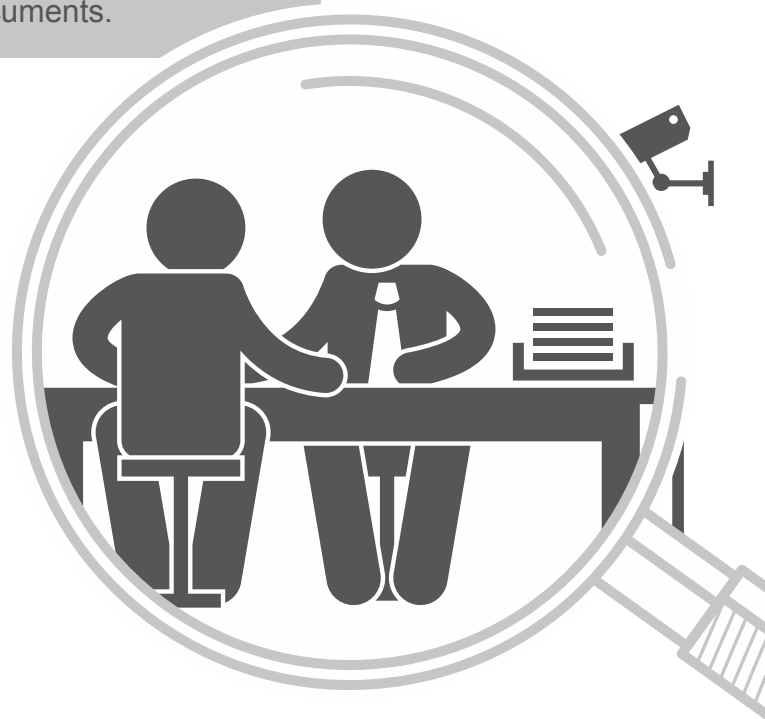
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp

# 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.

## 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