Manipal Cigna
Health Insurance

MANIPALCIGNA CLAIM FORM A

(To be completed by insured person/ claimant)
The issue of this form is not to be taken as an admission of liability

A. DETAILS OF PRIMARY INSURED:

a. Policy Number:

b. Sl. No/Certificate No:

c. Company/ TPA ID No

d. Name: SURNAME FIRST NAME MIDDLE NAME

e. Address:

City: State: Pin Code:

Phone No: Email ID:

B: DETAILS OF INSURANCE HISTORY:

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

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

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 ☐ Date: DD MM YYYY

Diagnosis:

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

f) If yes, Company Name:

C. DETAILS OF INSURED PERSON HOSPITALISED:

a. Name: SURNAME FIRST NAME MIDDLE NAME

b. Gender: Male ☐ Female ☐ Others ☐

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

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 HOSPITALIZATION:

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) Hospitalization due to: Injury Illness Maternity

d) Date of Injury / Date Disease first detected / Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y Y Y f) Time: H H : M M

g) Date of Discharge: D D M M Y Y Y Y h) Time: H H : M M

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:

a. Details of Treatment Expenses Claimed: **Amount (Rs.)**

i. Pre-Hospitalization Expenses:

ii. Hospitalization Expenses:

iii. Post-Hospitalization Expenses:

iv. Health Check up Cost:

v. Ambulance Charges:

vi. Others:

Total:

vii. Pre-Hospitalization Period: Days

viii. Post-Hospitalization Period: Days

b. Claim for Domiciliary Hospitalization: Yes No

c. Details of Lump sum/ Cash Benefit Claimed:

i. Hospital Daily Cash:

ii. Surgical Cash:

iii. Critical illness Benefit:

iv. Convalescence:

v. Pre/Post-Hospitalization Lump sum Benefit:

vi. Others (code):

Total:

Claim Documents Submitted Check List:

- Claim Form Duly Signed
- Copy of the Claim Intimation, if any
- Hospital Main Bill
- Hospital Break up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for Investigation
- Investigation Reports (Including CT/MRI/USG/HPE)
- Doctors Prescriptions
- Others

F. DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued By	Towards	Nos.	Amount (₹)
1.		D D M M Y Y Y Y		Hospital Main Bill		
2.		D D M M Y Y Y Y		Pre-hospitalization Bills: Nos		
3.		D D M M Y Y Y Y		Post-hospitalization Bills: Nos		
4.		D D M M Y Y Y Y		Pharmacy Bills		
5.		D D M M Y Y Y Y				
6.		D D M M Y Y Y Y				
7.		D D M M Y Y Y Y				
8.		D D M M Y Y Y Y				
9.		D D M M Y Y Y Y				
10.		D D M M Y Y Y Y				
				Total Claimed Amount		

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:

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-hospitalization claim, if any. 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.

Date: D D M M Y Y Y Y Place: Signature of the Insured:

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

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
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
c) Company TPA ID No.	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
SECTION B - DETAILS OF INSURANCE HISTORY		
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 hospitalization	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
SECTION C - DETAILS OF INSURED PERSON HOSPITALISED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male, Female or Others
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
SECTION D - DETAILS OF HOSPITALIZATION		
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) Hospitalization due to	Indicate reason of hospitalization	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
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	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
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Manipal Cigna
Health Insurance

MANIPALCIGNA HEALTH INSURANCE COMPANY LTD.
CLAIM FORM- PART B

(To be filled by Hospital)
The issue of this Form is not to be taken as an admission of liability
Please include the original Claim Form Part A in lieu of this form

(To be filled in block letters)

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. Procedure 4:		

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) 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: ____________________

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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-authorisation request	☐ CT/MR/USG/HPE investigation reports
☐ Copy of the Pre-authorisation 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 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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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

Signature and Seal of the Hospital Authority: ☐

Place: ☐☐☐☐☐☐☐☐☐

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
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		