PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED (IRDA License No. 006)

[formerly known as PARAMOUNT HEALTH SERVICES (TPA) PVT.LTD]

Plot no.A-442, Road No-28,M.I.D.0 Industrial Area, Wagale Estate, Ram Nagar, Vitthal Rukmani Mandir, Thane (W), Mumbai, Pin Code — 400 604

CLAIM ACKNOWLEDGMENT SHEET

Name of Insurer :		**PHS ID :**	
Insured Name :		**Employee No :**	
Patient Name :		**Mobile No :**	
Policy No :		**Phone (STD) :**	
Name of Corporate:			
Type of Claim (To be ticked) :	Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	**E-Mail ID of primary insured :**	

CLAIM DOCUMENT CHECK LIST

Sr. No	Description	Document Status(Y/N)	Remarks
1	IRDA Claim Form duly signed by the Insured & Hospital		
	Part-A: Duly signed by the insured with Claimed amount ,Mobile number & Email ID along with PHS ID		
	Part-B: Duly signed and stamped by hospital		
	Declaration form duly signed & stamped by the hospital in case treatment taken is under PPN/GIPSA hospitals.		
1.a	Policy Declaration Form duly signed by the Insured & Hospital hospitals.		
2	In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same.		
3	Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the AccountHolder Printed on the Cheque Leaf.		
4	ID Proof of Employee / Primary Insured- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID) . If Claim is above 1 lakh- PAN is mandatory with address Proof		
5	ID Proof of Patient- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID)		
6	Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care Treatment) / Death Summary (in Case of Death Claim)		
6.a	Copy of the Legal heir certificate (if the claim is for the death of the principle insured)		
6.b	Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)		
7	Policy Copy (**if individual policy)**		
8	64VB Compliance Certificate (**If individual policy)**		
9	Original Final Hospital bill with cost wise breakup of each Item		
10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)		
10.a	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip as received from the Vendor		
11	Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL		
12	Original bills, original Payment Receipts and investigation / Laboratory Reports		
13	Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions.		
14	Original copy of First Consultation letter and subsequent Prescriptions.		
15	Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not falls in GIPSA/PPN)		
16	**OTHER DOCUMENTS**		
16.a	Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)		
16.b	Original Sonography Report in case of Maternity Claim		
16.c	Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract Claim		
16.d	Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA)		
16.e	A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases)		
16.f	In case of claims where the insured has submitted documents to another insurance cofTPA, he needs to submit attested Photocopies of all the documents along with detailed claim settlement letter from the TPA and any unpaid bills and receipt for the same in originals.		

Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital

Claim Submitted by:		**Mobile No.**	
Date of Claim Submission:	DD /MM/YYYY HH:MM	**PHS Executive Name:**	
Claim Submitted at:	PHS - (Location) / Help Des!	**Signature:**	

Important Points to Remember:-

1. Please mark either **V** **or** x against respective check box
2. Date of File Received will be considered as next working day for Claim Files picked up at Help Desk
3. Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital
4. The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our document recovery team will contact you on receipt of your claim documents by us
5. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest ManipalCigna Branch.
Registered & Corporate Office: 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:** servicesupport@manipalcigna.com
CIN: U66000MH2012PLC227948
The issue of this Form is not to be taken as an admission of liability
(To be filled in Block Letters) - PART A - To be filled by Insured

ManipalCigna Health Insurance

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 GROUP INSURANCE POLICY CLAIM FORM A

SECTION I- TO BE COMPLETED BY INSURED PERSON/ CLAIMANT

A. DETAILS OF POLICY HOLDER:

a. Name of Corporate/ Group:

b. Master Policy Number: c. Certificate of Insurance Number:

d. Company/ TPA ID No:

e. Name of Policy Holder: FIRST NAME MIDDLE NAME LASTNAME

f. Address:

City: State: Pin Code:

g. Date of Birth: DD MM YYYY Age: Years Gender: Male Female

h. Occupation:

i. Telephone Number: j. Phone No:

k. Email ID:

B: DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other 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 THE INSURED IN RESPECT OF WHOM CLAIM IS MADE (IF OTHER THAN POLICY HOLDER)

a. Name of Insured Person:

b. Member ID of the Insured Person:

c. Date of Birth: DD MM YYYY d. Occupation: e. Gender: Male Female

f. Telephone Number: g. Phone No:

h. Email ID:

I. Relationship with Policy Holder:

j. Address, if different from above:

D: DETAILS OF HOSPITALIZATION / EVENT:

a) Name and Address of the Hospital:

City: State: Pin Code:

b) Room Category Occupied: Ward Shared room Single Private room Deluxe Suite

Any Other

c) Hospitalisation 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

Any Other

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 BENEFITS CLAIMED: (TO BE FILLED BY CLAIMANT AS APPLICABLE)

a. Benefit	Amount (Rs.)
Others: Code	
Total claimed Amount	
Pre-hospitalisation Period: Days	
Post-hospitalisation Period: Days	

Check List of Enclosures for Submission of Claim* (as applicable)

- Original copy of consultations
- Hospital discharge summary in original
- Hospital main bill in original
- Investigation reports, originals of X Ray, MRI, CT films, HPE, ECG
- Pharmacy bills, prescription and invoices
- KYC documents (photo ID proof, address proof, recent passport size photograph)
- Payment receipt.
- Bills from registered service provider (Road Ambulance cover)
- Disability certificate, Fitness certificate, Rest certificate
- Copy of claim intimation, if any
- Claim form duly signed
- Operation Theatre Notes (if applicable)
- Hospital break up bill
- Medical Practitioner's reference slip for investigation
- MLC/ FIR report, post mortem report if applicable and conducted
- Cancelled cheque with name for NEFT payment
- Death summary, death certificate, legal heir certificate if applicable
- Income or salary certificate, ITR
- Other insurer details and claims settlement letter if applicable
- Any additional documents available and related to the case**

** Note that We can call for any additional documents from You pertaining to the claim which can be of support in claim assessment.
*Please refer annexure for additional documents required for claim under any Optional benefits (as applicable).

F. DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued By	Towards	Nos.	Amount (₹)
1.		D D M M Y Y Y Y				
2.		D D M M Y Y Y Y				
3.		D D M M Y Y Y Y				
4.		D D M M Y Y Y Y				
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. PLEASE SUBMIT THE FOLLOWING DOCUMENTS IN CASE CLAIM AMOUNT EXCEEDS RS. 100,000 (AS PER KYC NORMS):

a. Recent passport size photograph (less than six months old).

b. Proof of Identity (Any one of the mentioned documents).
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/ Letter from a recognized public authority verifying the identity of the customer.

c. Proof of Residence (Any one of the mentioned documents)
Telephone bill/ Attested current statement of Bank account details/ Letter from any recognized public authority/ Electricity bill provided it is not older than six months from the date of insurance contract / Ration card/ Passport

H. DETAILS OF POLICY HOLDER'S BANK ACCOUNT:

Please furnish the details below along with copy of cancelled cheque.

a) PAN: b) Account Number:

c) Bank Name:

d) Branch Name:

e) IFSC Code: f) MICR Code:

g) Cheque / DD Payable Details:

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.

I: DECLARATION BY THE 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.

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

SECTION II: TO BE FILLED BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH):

Name of Nominee:

Address:

City: State: Pin Code:

Date of Birth: D D M M Y Y Y Y

Relationship with the Deceased:

Telephone Number: Phone Number:

Email ID:

DECLARATION BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH):

I/We hereby declare that the foregoing particulars are true & correct to the best of my knowledge and belief. I also authorize Insurance Company to make payment of the claim admissible as per terms, conditions and limitations to the Insured person or his legal heir as full and final settlement. I/We will keep indemnified and hold ManipalCigna Health Insurance Co. harmless from any claim under this policy by any third party.

Date: D D M M Y Y Y Y Place: Signature:

SECTION III: TO BE FILLED BY TREATING DOCTOR WHO ATTENDED THE INSURED

Name of the Insured ('Patient'):

Date of Birth: D D M M Y Y Y Y Age: Years

1. Are you the patient's usual medical attendant? **Yes** **No**

   a. If Yes, since when? D D M M Y Y Y Y

   b. If you have treated him/her for any previous illness or injury, please give details: _____

2. Details of the consultation by the Patient for present illness/ injury.

   a. Date of first consultation: D D M M Y Y Y Y

   b. Presenting Complaints: _____

   c. Nature of Illness/ Injury: _____

   d. History reported: _____

   e. Extent of Illness/ Injury: _____

   f. Diagnosis: _____

   g. Treatment given: _____

   h. If hospitalized:

   Date of Admission: D D M M Y Y Y Y Time of Admission:

   Date of Discharge: D D M M Y Y Y Y Time of Discharge:

3. Has the patient sustained a similar Illness/ injury previously or aggravated a pre-existing condition? **Yes** **No**

   If Yes, please give details: _____

4. If injury, Cause of Present Injury

   Self-Inflicted Road Traffic Accident Substance Abuse/ Alcohol abuse Other:

   Please provide details of cause of injury: _____

5. Is the cause traceable to any disease, previous injuries: **Yes** **No**

   If Yes, please give details: _____

6. Are Injuries sustained in this accident the sole cause of disablement: **Yes** ☐ **No** ☐

7. If injury, please specify the number of days when the injured person is advised rest/unfit and should be confined to bed/house as the direct and sole consequence of the injury sustained

   From: D D M M Y Y Y Y To: D D M M Y Y Y Y

   a. Will the Injured person be able to attend to his/her normal duties? **Yes** ☐ **No** ☐

   b. If Yes, from what date: D D M M Y Y Y Y

8. Has the accident/ illness resulted into loss of hands/ feet/ eye/s or permanent disability of any other type which may prevent Insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever?

   Yes ☐ **No** ☐

   If Yes, please give details: _____

   _____

9. Is the person suffering from any disease or illness apart from his injury which may tend to retard recovery?

   Yes ☐ **No** ☐

   If Yes: Give particulars: _____

10. If injury, was he/she under the influence of alcohol/intoxicants or drugs at the time of accident? **Yes** ☐ **No** ☐

11. Nature of disablement:

   a. Permanent Total Disablement **Yes** ☐ **No** ☐

   b. Permanent Partial Disablement **Yes** ☐ **No** ☐

   c. Please specify percentage: _____%

12. Has the present illness resulted in permanent neurological deficit: **Yes** ☐ **No** ☐

   If Yes, please provide duration: _____ months

13. Will the present illness require any major organ/ bone marrow transplant: **Yes** ☐ **No** ☐

   If Yes, please provide details: _____

   _____

14. Has the present illness resulted in loss of speech/loss of hearing/loss of sight: **Yes** ☐ **No** ☐

   If Yes, please provide details with duration: _____

   Is this loss irreversible: **Yes** ☐ **No** ☐

15. In case of injury due to major burns:

   a. Nature and Extent of Burns Injury: _____

   b. Percentage of surface area of Burns: _____

16. Has the present condition resulted in inability to perform following daily activities:

   Washing: **Yes** ☐ **No** ☐ Dressing: **Yes** ☐ **No** ☐

   Transferring: **Yes** ☐ **No** ☐ Toileting: **Yes** ☐ **No** ☐

   Feeding: **Yes** ☐ **No** ☐ Mobility: **Yes** ☐ **No** ☐

17. Has the present illness resulted in deterioration of intellectual/ social functioning and require continuous supervision of the insured person:

   Yes ☐ **No** ☐

18. Has the present illness resulted in deterioration of intellectual/ social functioning and require continuous supervision of the insured person:

   Yes ☐ **No** ☐

19. In case of Coma:

   Please specify the cause and severity of coma: _____

   Are life support measures necessary to sustain life? **Yes** ☐ **No** ☐

   Extent of neurological deficit: _____

20. Was the history provided by the Insured ('Patient')/ others? **Yes** ☐ **No** ☐

If 'others' please furnish details below: _____

a. Name and relation with the Insured: _____

21. Has the patient been referred to any other Doctor for current / associated ailment? **Yes** ☐ **No** ☐

If so, please furnish details below:

a. Name and address of the doctor / hospital: _____

_____

I hereby state that I have treated the Patient in connection with the above condition and that the facts as given above are correct to the best of my knowledge.

Name of the Doctor:

Registration Number:

Qualification:

Specialization:

Address:

City: State: Pin Code:

Contact Number:

Date: D D M M Y Y Y Y Place: Seal and Signature:

SECTION IV: TO BE FILLED BY EMPLOYER/GROUP POLICYHOLDER

1. Name of the Company/ Group Policyholder:
2. Address & Contact Details of the Company:
3. Name of the Employee:
4. Date of Joining Service: D D M M Y Y Y Y 5. Designation:
6. Please provide details of the leave availed by the employee, specifying the type of leave.

Sr. No.	Date from which leave is taken	Date when resumed duties	No. of Days	Type of Leave	In case of Sickness Leave, medical certificate produced- Yes/ No	Reason for Leave
	D D M M Y Y Y Y	D D M M Y Y Y Y				
	D D M M Y Y Y Y	D D M M Y Y Y Y				
	D D M M Y Y Y Y	D D M M Y Y Y Y				
	D D M M Y Y Y Y	D D M M Y Y Y Y				
	D D M M Y Y Y Y	D D M M Y Y Y Y				

Signature and Seal of the authorized signatory of the Company:

Name of the Authorised Signatory:

Designation:

Date: D D M M Y Y Y Y

Place:

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

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION I- TO BE COMPLETED BY THE INSURED PERSON		
A. Details of Policy Holder:		
a. Name of Corporate	Enter the company name	Free Text
b. Master Policy Number	Enter the policy number	As allotted by the insurance company
c. Certificate of Insurance Number	Enter the policy number	As allotted by the insurance company
d. Company/ TPA ID No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
e. Name of Policy Holder	Enter the Full Name of the Policy Holder	First Name, Middle Name, Surname
f. Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
g. Date of Birth (DD/MM/YYYY), Age, Gender	Enter Date of Birth of Policyholder, Age and gender	Use DD/MM/YYYY format for Date of Birth and mention years for Age
h. Occupation	Indicate Occupation of Policy Holder	Please specify the Occupation
i. Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
j. Phone No	Enter the Phone Number of Policyholder	Please enter a 10 digit number
k. Email ID	Enter E-mail Address of Policyholder	Complete E-mail Address
B. Details of Insurance History		
Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use DD/MM/YYYY format
Company Name	Enter the full name of the Insurance Company	Name of the organization 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
Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use DD/MM/YYYY format
Diagnosis	Enter the diagnosis details	Open Text
Previously covered by any other Mediclaim / Health Insurance	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
Company Name	Enter the full name of the Insurance Company	Name of the organization in full
C. Details of the Insured in respect of whom claim is made		
a. Name of Insured Person	Enter the Full Name of the Insured	First Name, Middle Name, Surname
b. Member ID of the Insured Person	Enter the member ID number	As allotted by the Insurance Company
c. Date of Birth (DD/MM/YYYY)	Enter Date of Birth of Insured	Use DD/MM/YYYY format
d. Occupation	Indicate Occupation of Insured	Please specify the Occupation.
e. Gender	Indicate Gender of Insured	Tick Male or Female
f. Telephone Number	Enter the Phone Number of Insured	Include STD code with telephone number
g. Phone No	Enter the Phone Number of Insured	Please enter a 10 digit number
h. Email ID	Enter E-mail Address of Insured	Complete E-mail Address
i. Relationship with Policy Holder	Indicate Relationship of Insured with Policyholder	Please specify the relationship
j. Address if different from above	Enter the Full Postal Address of insured	Include Street, City, State and Pin Code
D. Details of the Insured in respect of whom claim is made		
a. Name and Address of the Hospital	Indicate the Full Name and Postal Address	Indicate the Full Name of Hospital Include Street, City, State and Pin Code
b. Hospitalisation due to (Illness/ Injury/ Maternity)	Indicate reason of hospitalisation	Tick the right option
c. Room category occupied	Indicate the room category occupied	Tick the right option
d. Date (DD/MM/YYYY) and Time of Injury/ Date of disease first detected/ Date of delivery	Enter the Date and Time of Injury/Death as the case may be	Use DD/MM/YYYY format Use HH:MM format
e. Date/ Time of Admission	Enter the Date and Time of Admission	Use DD/MM/YYYY format Use HH:MM format
f. Date/ Time of Discharge	Enter the Date and Time of Discharge	Use DD/MM/YYYY format Use HH:MM format
g. 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
E. Details of benefits Claimed		
a. Benefit	Name of the cover for which claim is being made	Enter the full name as mentioned in Policy Schedule/Certificate of Insurance
b. Amount	Amount which is being claimed	Enter the amount which is being claimed
c. Checklist of enclosures for submission of claim	Indicate which supporting documents are submitted	Tick the right option
F. Details of Bills enclosed		
Indicate which bills are enclosed with the amount in rupees		
G. Documents Enclosed		
a. Recent passport size photograph	Passport size photograph	Provide less than six months old passport size photograph
b. Proof of identity	Identity proof is to be submitted	Provide identity proof from a list of mentioned documents
c. Proof of residence	Proof of residence is to be submitted	Proof of residence from a list of mentioned documents
H. Details of Primary Insured's Bank account		
PAN	Enter the permanent account number	As allotted by the Income Tax Department
Bank Name	Enter the Bank name	Name of the Bank in full
Bank Branch	Enter the Bank branch name	Name of the Bank branch in full
Bank Account Number	Enter the Bank account number	As allotted by the Bank
IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
Cheque/ DD Payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
I. Declaration by the Insured Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

ANNEXURE:

Options	Additional documents required
Critical Illness - Indemnity Cover	• Medical certificate confirming the diagnosis of Critical Illness • Discharge certificate/ card from the Hospital, if any. • Investigation test reports confirming the diagnosis. • First consultation letter and subsequent prescriptions. • Indoor case papers, if applicable. • Specific documents listed under the respective Critical Illness. • Any other documents as may be required by Us. • In those cases where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.
Critical Illness - Benefit Cover	• Medical certificate confirming the diagnosis of Critical Illness. • Discharge certificate/ card from the Hospital, if any. • Investigation test reports confirming the diagnosis. • First consultation letter and subsequent prescriptions. • Indoor case papers, if applicable. • Specific documents listed under the respective Critical Illness. • Any other documents as may be required by Us. • In those cases where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.
Accidental Death Benefit	• Copy of FIR/ Panchnama /police inquest report (if conducted) duly attested by the concerned police station. • Copy of medico legal certificate (if conducted) duly attested by the concerned Hospital. • Original death certificate issued by the office of Registrar of Birth & Deaths. • Copy of post mortem report, if conducted. • Copy of chemical analysis / forensic report, if applicable. • Death summary, if death in Hospital. • Copies of medical records, investigation reports, if admitted to Hospital. • Identity proof of Nominee or original succession certificate/original legal heir certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased Insured Person. • Any other document as may be deemed necessary by Us to evaluate the claim.
PTD/PPD Cover	• Copy of FIR/ Panchnama /police inquest report (if conducted) duly attested by the concerned police station. • Copy of medico legal certificate(if conducted) duly attested by the concerned Hospital. • Disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board (or) certificate from the treating Medical Practitioner certifying the extent of disability. • Original treating Medical Practitioner's certificate describing the disablement. • Original discharge summary from the Hospital. • Photograph of the Insured Person reflecting the disablement;. • Copies of medical records, investigation reports, if admitted to Hospital. • Any other document as may be deemed necessary by Us to evaluate the claim.
Accumulate Cover	• Claim form along with the invoices, • Treating Medical Practitioner's prescription, reports, duly signed by the Insured Person
Out- Patient Cover	• Invoices, • Treating Medical Practitioner's prescription, • Reports, • Duly signed by Insured Person
Dental Expenses Cover & Vision Expenses Cover	• Claim form • Invoices, • Treating Medical Practitioner's prescription, • Reports, duly signed by the Insured Person as the case may be • For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee or Dependent must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable: • A full description of the proposed Treatment; • X-rays and study models; • An estimate of the cost of the Treatment.

Refractive Error Correction Beyond +/- 5 Expenses Cover	• Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment.
OPD Physiotherapy Charges Cover	• Bills supported by prescription from registered Medical Practitioner specifying the physiotherapy Treatment taken as an Out-Patient in the Hospital.
Worldwide Emergency Cover	• In an unlikely event of the Insured Person requiring Emergency medical Treatment outside India, the Insured Person must notify Us either at Our call centre or in writing within 48 hours of such admission. • The Insured Person shall file a claim for reimbursement in accordance with the Policy Terms and Conditions.
Road Ambulance Cover	• Bills from registered service provider.
Domiciliary Hospitalisation Cover	• The Insured Person should submit the claim documents at his/her own expense within 15 days of completion of Treatment for eligible period of cover.
Pre-hospitalisation Medical Expenses Cover and Post- hospitalisation Medical Expenses Cover	• The Insured Person should submit the Post-hospitalisation Medical Expenses Cover claim documents at his/her own expense within 15 days of completion of post-hospitalisation Treatment or eligible post-hospitalisation period of cover, whichever is earlier. • We shall receive Pre-hospitalisation Medical Expenses Cover claim and Post- hospitalisation Medical Expenses Cover claim documents either along with the In-patient Hospitalisation papers or separately and process the same based on merit of the claim subject to Policy terms and conditions, derived on the basis of documents received. This Benefit shall be honoured and the claim can be taken up for processing only after settlement of main hospitalisation claim.
Routine Immunisations Cover	• Immunisation or vaccination chart, • Medical Practitioner's prescription and supporting pharmacy bills.
Home Nursing Charges Cover	• Bills from registered nursing service provider.
Health Check Up Benefit	• The Insured Person shall seek an appointment by calling Our call centre. • We will facilitate the Insured Person's appointment and will guide him/her to the nearest Network Provider for conducting the medical examination. Reports of the medical tests can be collected directly from the centre. A copy of the medical reports will be retained by the medical centre which will be forwarded to Us along with the invoice for reimbursement.
Expert Opinion On Critical Illness Cover	(a) Receive request for Expert Opinion on Critical Illness • The Insured Person can submit a request for an expert opinion by calling Our call centre or register his/her request through email. (b) Facilitating the process • We will schedule an appointment or facilitate delivery of medical records of the Insured Person to a Medical Practitioner. The expert opinion is available only in the event of the Insured Person being diagnosed with a covered Critical Illness.
Compassionate Cover for family member in case of Emergency or Accident	• Certificate of Medical Practitioner recommending personal attendance of an immediate family member. • Railway travel ticket/ Air flight boarding pass
Air Ambulance Cover	• Air ambulance ticket for registered service provider.
Emergency Evacuation Cover	• In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing. • Emergency medical evacuations shall be pre-authorised by Us. • Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved.
Medical Equipment Cover	• Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred
Bariatric Surgery Cover	• Certificate by qualified medical surgeons indicating the medical necessity of the procedure.
Birth Control Procedure Cover	• All medical records and treating Medical Practitioner's certificate on the indication.
Infertility Treatment Cover	• Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure.
Deductible (Corporate/Aggregate/ Per Claim)	• Any claim towards Hospitalisation during the Policy Year must be submitted to Us for assessment in accordance with the claim process laid down under the Policy Terms and Conditions towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with the Policy Terms and Conditions. • Wherever such Hospitalisation claims as stated under the Policy Terms and Conditions is being covered under another policy held by the Insured Person, We will assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be.

ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
OR Nearest ManipalCigna Branch.
Registered & Corporate Office: 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: servicesupport@manipalcigna.com **CIN:** U66000MH2012PLC227948

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

ManipalCigna Health Insurance

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 GROUP INSURANCE POLICY 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 ☐

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:

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

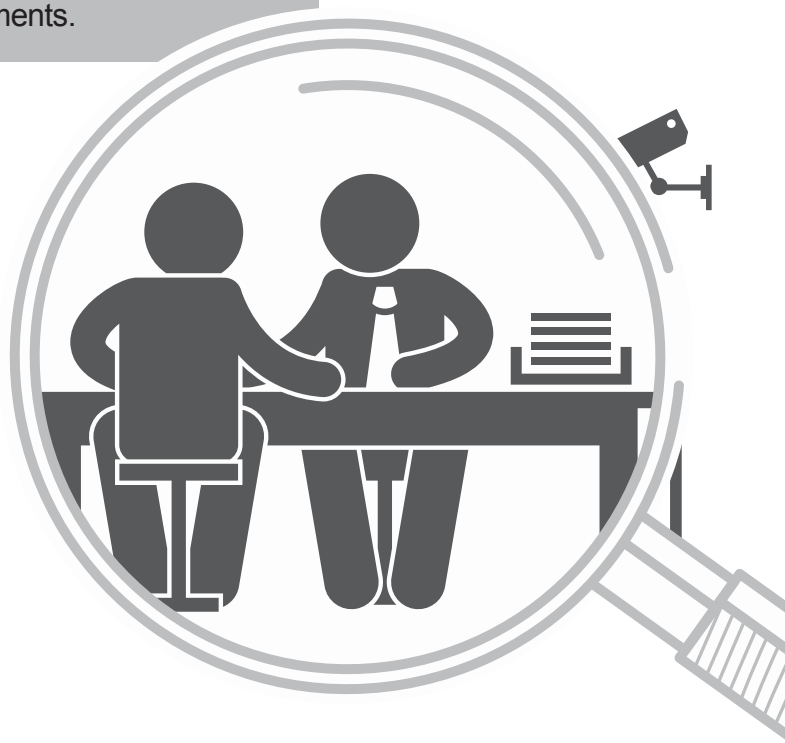
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non-network hospital	Tick the right option
d) 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
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 duringpolicyissuance. **YES** ☐ **NO** ☐

Weshallusebelowmentioned information from the policy for payment of your claim:

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

ManipalCigna ProHealth Group Insurance Policy | UIN - CTTHLGP18023V021718 | April 2019 onwards

Paramount Health
Your link to good health

POLICY DECLARATION FORM

Date:……

Name of the Hospital :……

Address:……

PATIENT NAME (BLOCK LETTERS):…… AGE/SEX :……

Mobile No of Patient:……

Date of Admission:…… Date of Discharge:……

Undertaking by the Patient regarding Heath Insurance Policy
(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I declare that I do not have any health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I declare that I have health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास एक स्वास्थ्य बीमा पॉलिसी है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Does not have insurance coverage hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)

- Patient has health insurance coverage but out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature: ……

Name of the Hospital Representative & Hospital Seal