

**REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY
 PART - C (Revised)**

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER/HOSPITAL:

TO BE FILLED IN BLOCK LETTERS

a) Name of Insurance Company: **ManipalCigna Health Insurance Company Limited**

b) Toll Free Phone Number: 1800-102-4462

c) Toll free fax:

d) Name of Hospital:

i) Address:

ii) Rohini ID:

iii) Email ID:

TO BE FILLED BY THE INSURED / PATIENT:

a) Name of the Patient: S U R N A M E F I R S T N A M E M I D D L E N A M E

b) Gender: Male Female Third Gender c) Age: Years Months d) Date of Birth: D M M Y Y Y Y

e) Contact Number: f) Contact Number of Attending Relative:

g) Insured Card ID Number:

h) Policy Number / Name of Corporate: i) Employee ID:

j) Currently do you have any other Mediclaim / Health Insurance: Yes No

Company Name:

Give Details:

k) Do you have a Family Physician: Yes No l) Name of the Family Physician:

m) Contact Number, if any: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

n) Current address of Insured Patient:

o) Occupation of Insured Patient:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL:

a) Name of the Treating Doctor:

b) Contact Number:

c) Nature of Illness / Disease with Presenting Complaints:

d) Relevant Critical Findings:

e) Duration of the Present Ailment: Days i. Date of First Consultation: D M M Y Y Y Y

ii. Past History of Present Ailment, if any:

f) Provisional Diagnosis:

i. ICD 10 Code:

g) Proposed Line of Treatment : Medical Management Surgical Management Intensive Care
 Investigation Non Allopathic Treatment

h) If Investigation and / or Medical Management, provide details:

i) Route of Drug Administration:

i) If Surgical, name of Surgery: i. ICD 10 PCS Code:

j) If other Treatments, provide details:

k) How did Injury Occur?:

l) In case of Accident:

i. Is it RTA?: Yes No

ii. Date of Injury: D D M M Y Y Y Y

iii. Reported to Police: Yes No

iv. FIR No.:

v. Injury / Disease caused due to Substance Abuse / Alcohol Consumption: Yes No

vi. Test conducted to establish this: Yes No (If Yes, attach reports)

HOSPITAL DECLARATION:

1. We have no objection to any authorised TPA / Insurance Company official verifying documents pertaining to hospitalisation.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. We agree that tpa / insurance company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
4. The patient declaration has been signed by the patient or by his representative in our presence.
5. We agree to provide clarifications for the queries raised regarding this hospitalisation and we take the sole responsibility for any delay in offering clarifications.
6. We will abide by the Terms and Conditions agreed in the MOU.
7. We confirm that no additional amount would be collected liom the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).
8. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
9. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates,the adhorized TPA / Insurance Company reserves the right to recoverthe same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws.

Hospital Seal

Doctor's Signature

Date :

Time :

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital, duly signed by the Patient/Representative.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Diagnostic Tests Reports and Receipts supported by note from the attending Medical Practitioner/Surgeon recommending such Diagnostic Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon giving the patient's condition and advice on discharge.