COST ESTIMATE

1. A fully completed form facilitates its processing.
2. Write clearly in black ink and **BLOCK CAPITALS**.
3. Complete a separate form for each patient and for each currency.
4. Return this form prior to admission to: **authorization@cigna.com**
   Fax Europe, Africa and Middle East +32 3 217 66 20
   Fax North and South America +1 305 908 9091
   Fax Asia and Pacific + 603 2178 1499

Patient

Personal reference n° /

Family name and first name

Date of birth D M Y Gender ◯ M ◯ F

Health care provider

Name

Address (Including zip code, city and country)

Cigna provider ID (if available)

Contact person

Telephone Fax

Email

Medical information(1)

Diagnosis or reason for admission or code (ICD10, DRG, etc.)

Medical report on the illness/treatment attached? ◯ No ◯ Yes

Type of treatment or surgery

Name and contact details of the doctor

Expected costs

Hospitalisation with overnight stay? ◯ No ◯ Yes

Admission date D M Y Expected discharge date D M Y

Doctors' fees with relevant breakdown and currency(2):

Other medical expenses (medicines, x-rays, lab, etc.) and currency

Room type ◯ Private ◯ Semi-private ◯ Ward Cost per day Currency

Should a guarantee of payment be sent? ◯ No ◯ Yes

Signature

I hereby confirm that I have read and fully understood Cigna's Privacy policy (https://www.cignahealthbenefits.com/en/privacy) and give my consent to the processing of my personal information (including medical data) as defined in Cigna's Privacy policy.

Signature of the plan member and date D M Y Stamp of the hospital/doctor

(1) All information subject to medical confidentiality may be sent for the attention of our Medical consultant in a sealed envelope or to medicalboard@cigna.com. Diagnosis and medical reports must be legible and without abbreviations.
(2) In case of surgery, individual fees of each member of the surgical team; in case of conservative treatment, fees of the main treating doctors.

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