

COST ESTIMATE

- 1. A fully completed form facilitates its processing.
- 2. Write clearly in black ink and **BLOCK CAPITALS**.
- Complete a separate form for each patient and for each currency.
 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

Patient Fax Asia and Pacific + 603 2178 1499																														
Personal reference n°				/																										
Family name and first name																														
Date of birth D	м			Y					(Gen	nder	С) M	С) F															
Health care provider																														
Name																														
Address (Including zip code,	city	/ and	d co	untr	·y)																									
Cigna provider ID (if availab	e)																													
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? ONO Yes																														
Type of treatment or surgery Name and contact details of the doctor																														
Expected costs																														
Hospitalisation with overnight stay? ONO OYes																														
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	C)Se	mi-p	oriva	ate		С	W	/ard	ł		Cos	st pe	er d	ay									(Curre	enc	y			
Should a guarantee of payment be sent? ONO Yes																														
Signature	Signature																													
OI hereby confirm that I have reac processing of my personal informa	l and	fully (inclu	unde	ersto	od C	igna's	S Priv	acy efir	/ pol	licy (in Ci	http: ana's	s://w	/ww.	cign	ahea	lthb	enefi	its.co	om/e	n/pr	ivac	y) ar	nd gi	ve m	y cor	ısen	t to t	he		
Providence of the second months				,											- / •															
Signature of the plan memb	er a	nd c	late	D			м			`	Y							Sta	amp	of	the	ho	spit	al/d	octo	or				

 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.
 In case of surgery, individual fees of each member of the surgical team; in case of conservative treatment, fees of the main treating doctors.