亞 洲 保 險
ASIA INSURANCE

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索償表格
CLAIM FORM

醫療保險－住院及手術
MEDICAL INSURANCE CLAIM FORM - HOSPITALIZATION & SURGICAL PROCEDURE

Claims Document Checklist 索償文件參考表

Basic Requirements (must be completed)
- ☐ Part I completed by the patient with member cert number and signature
- ☐ Part II completed by the Attending Physician/ Surgeon with signature and chop
- ☐ Payment receipts with patient's name, treatment date, diagnosis and breakdown of charges:
  First Claim: Original receipts
  Second Claim: Certified true copy of receipts and claims statement advice by other insurer, if applicable

Additional Requirements (if applicable)
- ☐ Referral letter for Specialist consultation/ Private nursing/ Home nursing/ Home healthcare/ any kind of therapy treatment
- ☐ Copies of histopathology, endoscopic, diagnostic, laboratory tests reports, and surgical summary

No reimbursement or claims shall be made for:
- Claim(s) submitted after 90 days from the date of discharge/treatment
- Insufficiency of required information

基本要求 (必須填妥)
- ☐ 由病人填妥第一部份, 包括病人保戶號碼及簽署
- ☐ 由主診/外科醫生填妥第二部份, 包括醫生簽署及蓋章
- ☐ 醫療賬單收據: 顯示病人姓名、診治日期、病症及各收費項目
  首次索償: 正本收據人
  餘額索償: 其他保險公司發回之核實副本收據及賠償結算通知書(如適用)

額外要求 (如適用)
- ☐ 附上專科醫生/私家看護/家居看護或其他治療項目之醫生轉介信
- ☐ 附上病理學、內窺鏡、診斷性化驗、檢驗報告及手術撮要副本

根據以下情形，賠償申請將不獲辦理:
- 賠償申請表於出院/治療日90天後遞交
- 所需資料不足

本表格適用於住院或日間手術賠償
This form is applicable to both inpatient and day case procedure claim

甲部 - 由病人填寫
PART I - TO BE COMPLETED BY THE PATIENT

保單持有人 / 僱主名稱
Name of Policyholder/ Employer

僱員 / 受保人姓名 (只限團體保單) Name of Employee/ Insured Member (For group insurance policy only)	保單編號 Policy No.
保戶號碼/職員號碼 (如適用) Certificate No./ Staff No. (if applicable)	日間聯絡電話 Daytime Contact Tel No.

病人姓名 Name of Patient	身份証號碼 I.D. Card No.	
職業 Occupation	出生日期 Date of Birth	性別 Sex ☐ 男 M ☐ 女 F

與保單持有人關係
Relation with the Policyholder
☐ 本人 Self ☐ 配偶 Spouse ☐ 子女 Child
☐ 僱員 / 成員 Employee ☐ 僱員家屬 Dependent of Employee

(1) 閣下是否曾因同一病況而接受治療?
Have you ever received any prior treatment for this or related conditions? ☐ 沒有 NO ☐ 有 YES

醫生姓名
Doctor's Name _____

地址
Address _____

日期
Date(s) _____

(2) 有關此次住院 / 手術，閣下有否申請其他保險賠償 ?
Are you making any other insurance claim as a result of this hospitalization/surgery ? ☐ 沒有 NO ☐ 有 YES

保險公司名稱
Name of Insurance Company _____ 保單號碼 Policy No. _____

☐ 請退回單據以便申請其他保險賠償
Please return receipts for other insurance claims.

(3) 此次住院 / 手術是否由於一宗意外引致 ?
Was the hospitalization/surgery resulting form/related to any accident? ☐ 不是 NO ☐ 是 YES

日期 Date _____ 時間 Time _____ 地點 Place _____

經過
Brief Description _____

重要事項 IMPORTANT NOTES

Any personal information collected by the Company may be used, stored or disclosed to any individual or organisation to evaluate this application, to provide our services and products to you, including administering, maintaining, managing and operating such services and products, or to provide subsequent services. Requests for personal data access or correction may be addressed to Data Protection Officer of the Company.
本公司所收集的任何個人資料，將用於、儲藏於任何個人及機構以用核實申請，提供服務及產品包括管理、維持、處理及運作有關服務及產品，及提供售後服務的用途。閣下可聯絡本公司的個人資料保護主任，要求更改任何交予本公司的個人資料;

It is our policy to comply with the requirement of the Personal Data (Privacy) Ordinance (Cap. 486) of the laws of the Hong Kong Special Administrative Region. Details of the Personal Information Collection Statement ("PICS"), please kindly refer to our website www.asiainsurance.hk. For any questions, requests for such access or correction can be made in writing to the Personal Data Protection Officer, Asia Insurance Company Limited, 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong SAR.
本公司會遵守「個人資料(私隱)條例」(香港法例第486章)。關於個人資料收集聲明，請瀏覽亞洲保險網頁 www.asiainsurance.hk.。如有任何疑問，需查閱或更正以上之個人資料，可致函香港上環干諾道西一百一十八號八樓亞洲保險有限公司的個人資料保護主任提出。

聲明及授權書 DECLARATION & AUTHORIZATION

I hereby authorise any hospital, physician, insurance company or organisation that has any records or knowledge of me or my health, to furnish to Asia Insurance Company Limited or its authorised representative, any and all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records for application and underwriting purpose. A photostat copy of this authorisation shall be considered as effective and valid as the original.
本人授權持有本人健康或任何資料之醫院、醫生、保險公司或機構，可以將部份或全部有關本人傷患之病歷、診斷報告及藥方等資料給予亞洲保險有限公司或其代理人作申請及核保之用。此授權書之影印本與正本具同等效力。

X _____ X _____

病人簽署/父母或合法監護人簽署(適用於18歲以下之病人) Signature of Patient/Parent or Legal Guardian (Applicable for age below 18) 日期 Date

P. T. O. 請轉後頁

乙部 — 由主診/外科醫生填寫，所需費用由索償人自行承擔
PART II – To Be Completed by Attending Physician / Surgeon at the Claimant's Own Expenses

Name of Patient (in full) 病人姓名(全名): _____

Date of Admission 入院日期(DD日/MM月/YY年)_____ Date of Discharge 出院日期(DD日/MM月/YY年)_____

Name of Hospital 醫院名稱: _____

Level of hospital ward 病房級別: ☐ Private 頭等房 ☐ Semi-private 二等房 ☐ Ward 三等房 ☐ Clinical Surgery 門診小手術

1. Clinical History 求診記錄:

a) Are you the patient's usual physician? 閣下是否病人的慣常醫生?

a) i. Yes是 ☐ please fill in question b 請填寫問題 b

ii. No 不是 ☐ Does the patient have any other usual / family doctor(s)? if Yes, please give us the name(s) and telephone no.
病人是否有其他的長期 / 家庭醫生? 如是者，請提供姓名及電話號碼 _____

b) Please provide all the consultation date(s) and the brief summary of the related disorder/illness. 請填寫診治日期及與是次病症相關之撮要。

_____

If you are referred by other doctor, please provide the doctor name, contact number and address. 如閣下乃其他醫生轉介，請提供該醫生的姓名、聯絡電話及地址。

_____

b) Date of the first consultation with the patient for this illness/ injury 病人就此疾病/受傷後, 首次向閣下求診的日期(DD日/MM月/YY年) _____

c) Symptom(s) / complaint(s) of the patient relating to this hospitalization / treatment / investigation 病人就此次住院 / 治療 / 檢驗所出現的相關症狀及主訴

_____

_____

d) How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症狀多久?_____

2. Hospitalization Details 住院詳情:

a) Final Diagnosis 最後的診斷_____ Date of Operation手術日期(DD日/MM月/YY年)_____

b) Name of the operation performed 手術的名稱 _____

c) Please give a brief discharge summary (including onset and duration of signs and symptoms / disease, etiology, types and results of major examinations, treatments, complications and follow up plan) 請提供出院撮要(包括開始時及持續出現的徵兆 / 症狀、病因、主要檢查的種類及結果、治療、併發症及覆診詳情)

_____

_____

d) Please provide reason(s) for hospitalization if this type of cases can be managed on day care / out-patient basis.
若此次病症能在日間護理 / 診所內進行治療，請提供住院原因。

_____

e) Had the patient been previously treated or hospitalized for the same or in related disability? If so, please give a brief summary of the following:
病人過去曾否就相同或相關病症而需接受診治或入院接受治療? 如是，請說明撮要。

Dates 日期	Disease / Disorder / Complaint 疾病 / 失調 / 申訴	Type of treatment / hospitalisation 治療 / 住院的詳情	Name of doctor / hospital 西醫姓名 / 醫院名稱

f) If the patient has consulted other physician(s) during this hospitalization period, please provide the following:
如於住院期間曾向其他醫生求診，請提供以下資料:

Name of the physician(s) consulted 醫生姓名 _____ Reason 原因 _____

What kind of treatment did the physician provide to the patient? 醫生提供給病人之治療詳情?

_____

g) Was the patient hospitalized as a result of recurrent episode or chronic illness or related to a previous complaint/ diagnosis.
If "yes", please provide date of first episode and details.
病人是次住院治療是否因繼發或慢性病病所引致或與以往的主訴/診斷有關?若答案為 "是"，請提供首次發病日期及詳情。

_____

h) Was the Medical condition due to or associated with the following? (Please tick the appropriate boxes)
上述情況是否出於或與以下問題關連(請在適當空格填上☑號)

☐ Accidental bodily injury 意外身體受傷
☐ Self-inflicted injury 自我傷害
☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Mental disorder 精神紊亂
☐ Refractive error 屈光不正
☐ Pregnancy 懷孕
☐ Infertility or sterilization 不育或絕育
☐ Contraception 避孕
☐ Treatment for cosmetic purpose 美容性質的治療
☐ Vaccination 疫苗接種
☐ Congenital condition 先天性疾病/異常
☐ Developmental condition 發育問題
☐ Hereditary condition 遺傳性問題
☐ General check-up 一般身體檢查
☐ Venereal disease, sexually transmitted disease or AIDS / HIV related illness 性病，性傳播疾病或愛滋病 / 愛滋病毒有關的疾病

_____ _____
Signature and chop of attending physician / Surgeon 主診醫生 / 外科醫生簽名及蓋章 Address and Telephone No. 地址及電話號碼

_____ _____
Name of attending physician / Surgeon & qualifications 主診醫生姓名 / 外科醫生姓名及資歷 Date日期(DD日/MM月/YY年)

Part II of this claim form is endorsed by the Hong Kong Medical Association and Medical Insurance Association of The Hong Kong Federation of Insurers.
本索償表格乙部已獲香港醫學會及香港保險業聯會屬下醫療保險協會認可。