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MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM

醫療保險－住院及手術賠償表

This form is applicable to both inpatient and outpatient surgical claim.

本表格適用於住院或門診手術賠償

PART 1 - TO BE COMPLETED BY THE PATIENT

甲部－由病人填寫

| | |
|---|------------------|
| Name of Policy Holder 保單持有人名稱： | |
| Name of Employee/Member 僱員／成員姓名： (For group insurance policy only) | Policy No. 保單編號： |
| Insured No./Certificate No. 保戶編號／受保證書編號 (If applicable 倘適用)： | |

| | | |
|---|---|--|
| Name of Patient 病人姓名： | I.D. Card No. 身份証號碼： | |
| Occupation 職業： | Date of Birth 出生日期： | Sex 性別： <input type="checkbox"/> M男 <input type="checkbox"/> F女 |
| Relationship to the Policy Holder 與保單持有人關係： | <input type="checkbox"/> Self 本人 | <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 |
| | <input type="checkbox"/> Staff/Member 僱員／成員 | <input type="checkbox"/> Dependent 僱員／成員家屬 |

(1) Have you had any prior treatment for this or related conditions?

閣下是否曾經因同一病況而接受治療？

NO 沒有 YES 有

Doctor's Name 醫生姓名：_____

Address 地址：_____

Date(s) 日期：_____

(2) Are you making any other insurance claim as a result of this hospitalization/surgery?

有關此次住院／手術，閣下有否申請其他保險賠償？

NO 沒有 YES 有

Name of Insurance Company 保險公司名稱：_____

Policy No. 保單號碼：_____

(3) Was the hospitalization/surgery a result of an accident?

此次住院／手術是否由於一宗意外引致？

NO 不是 YES 是

Date 日期：_____

Time 時間：_____

Place 地點：_____

Brief Description 經過：_____

DECLARATION & AUTHORIZATION 聲明及授權書：

I hereby declare that the above information given is true and correct.

I further authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to _____ or its authorized 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. A photostat copy of this authorization shall be considered as effective and valid as the original.

本人現聲明上述所填報的資料正確無訛。

本人茲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與 _____ 或其代理人。此授權書之影印本與正本具同等效力。

Date 日期

Signature of Patient 病人簽署

PART II - TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES
乙部 - 由主診醫生填寫，所需費用由索償人自行承擔

| | |
|--|-----------------|
| (1) Name of Patient 病人姓名： _____ | |
| (2) Hospitalization 住院 Name of hospital 醫院名稱： _____ Date of Admission 入院日期： _____ Date of Discharge 出院日期： _____ | |
| (3) Surgical procedure 手術 Date of operation 手術日期： _____ Name of the procedure 手術名稱： _____ Nature 性質： _____ | |
| (4) Chief complaints of the patient relating to this hospitalization/surgery 此次住院/手術的主要病因： _____ | |
| (5) Diagnosis of conditions 診斷： _____ | |
| (6) Brief discharge summary: (including treatments, investigation procedures, results, and/or any complications and follow up plan.) 出院撮要：(治療及以後治療計劃，包括診查辦法、結果、併發症及跟進計劃) | |
| (7) Date of the accident occurred or symptom first appeared. 首次出現病徵日期或意外發生日期。 | |
| (8) Date of first consultation for this condition or related illness 病人首次求診日期 | |
| (9) To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? 據閣下所知，病人以前曾否患有同類病況？ NO 沒有 <input type="checkbox"/> YES 有 <input type="checkbox"/> Please state dates and describe _____ 請說明何時及當時情況 _____ | |
| (10) Is the patient referred by another doctor? 病人是否經其他醫生轉介？ NO 不是 <input type="checkbox"/> YES 是 <input type="checkbox"/> Name and address of the referral doctor. _____ 轉介醫生的姓名和地址。 _____ | |
| Name of Attending Physician / Specialist (with qualifications) 主診/專科醫生的姓名(資歷) | Address 地址 |
| Signature of Attending Physician / Specialist 主診/專科醫生簽名 | Telephone 電話 |
| | Date 日期 |