亞 洲 保 險
Asia Insurance

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索償表格
CLAIM FORM

Business Centre: 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong. Tel: +852 3606 9346 Fax: +852 2899 2426 Email: medical@afh.hk
Macau Branch: Avenida da Praia Grande, No.762, Edificio China Plaza, 10 andar C-D, Macau. Tel: +853 2856 3166 Fax: +853 2857 0438 Email: asiamc@macau.ctm.net
Website: http://www.asiainsurance.hk

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

Claims Document Checklist 索償文件參考表

Basic Requirements (must be completed or submitted)
- ☐ Part I completed by you with member cert number and Patient Signature
- ☐ Part II completed by the doctor with Signature and Chop
- ☐ Payment receipts with patient's name, treatment date, diagnosis and breakdown of charges:
  First Claim: Original receipts
  Secord Claim: Certified true copy of receipts and claims statement advice by other insurer, if applicable

Additional Requirements (if applicable)
- ☐ Referral letter for specialist consultation or SRN nursing
- ☐ 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 (必須填妥或提供)
- ☐ 由你填妥第一部份，包括病人保戶號碼或職員號碼及病人簽署
- ☐ 由醫生填妥第二部份，包括醫生簽署及蓋章
- ☐ 醫療賬單收據：顯示病人姓名、診治時間、病症及各收費項目
  首次索償：正本收據
  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)
- ☐ 附上專科診治或私家看護之醫生轉介信
- ☐ 附上病理學、內窺鏡、診斷性化驗/檢驗報告及/或手術撮要副本

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

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

本表格適用於住院或門診手術賠償
This form is applicable to both inpatient and outpatient surgical claim

保單持有人 / 僱主名稱
Name of Policy Holder/Employer

僱員 / 成員姓名
Name of Employee/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
(DD日/MM月/YY年)

性別 Sex
☐ 男 M ☐ 女 F

與保單持有人關係
Relationship to the Policy Holder
☐ 本人 Self ☐ 配偶 Spouse ☐ 子女 Child
☐ 僱員 / 成員 Staff/Member ☐ 僱員 / 成員家屬 Dependent

(1) 閣下是否曾因同一病況而接受治療?
Have you had 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)
(DD日/MM月/YY年) _____

(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 a result of an accident ? ☐ 不是 NO ☐ 是 YES

日期 Date
(DD日/MM月/YY年) _____

時間
Time _____

地點
Place _____

經過
Brief Description _____

重要事項 IMPORTANT NOTES

亞洲保險有限公司（亞洲保險）可以運用、保存或透露以上之個人資料予任何人仕或機構，用以審核此項索償，或提供有關服務。若需查閱或更正以上之個人資料，請聯絡亞洲保險的資料保護主任。

Any personal information collected by Asia Insurance Co., Ltd. (Asia Insurance) may be used, stored or disclosed to any individual or organization to evaluate this claim, or to provide subsequent services. Requests for personal data access or correction may be addressed to the Data Protection Officer of Asia Insurance.

聲明及授權書 DECLARATION & AUTHORIZATION

本人現聲明上述所填報的資料正確無訛。 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。此授權書之影印本與正本具同等效力。

I hereby declare that the above information given is true and correct. I hereby authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to Asia Insurance 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.

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

X _____
Date 日期

P. T. O. 請轉後頁

乙部 – 由主診醫生填寫，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

Patient Name (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) Date on which the patient first consulted you related to 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）_____

b) 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

_____

_____

c) 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) Operation procedure(s) performed 手術的名稱_____

c) If the patient has consulted other physician during this hospitalization, please provide the following 如病人於住院期間曾向其他醫生求診，請提供以下資料:

Name of physician consulted 醫生姓名_____ Reason 原因_____

What treatment had the physician performed 治療詳情_____

d) 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）

_____

_____

e) 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。

_____

f) Has the patient taken any home leave during this hospitalization? If yes, please state the date, time and reason.
病人在住院其間有否請假外出？如有，請說明日期、時間及原因。

☐ YES 有 / ☐ No 否 _____

_____

g) Had the patient been previously treated or hospitalized for this or any in related disorders? If so, please give a brief summary (including diagnosis etiology, type of examination and treatment protocol of the previous disorder / illness.)
病人過去曾否就此疾病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(請列出病症、檢驗項目、治療方案。)

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
_____	_____	_____	_____

3. Professional Comment 專業意見:

a) In your opinion, was the patient hospitalized as a result of recurrent episode or a chronic illness or related to a previous complaint / diagnosis.
If " yes ", please provide date of the first episode and details.
就閣下意見，病人是次住院治療是否因繼發性或慢性疾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。

_____

_____

b) Was the 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

4. Others 其他:

(1) 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。

_____ _____

(2) 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。

_____ _____

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。