BUPA Clinical Claim Form 保柏門診賠償申請表

BUPA Health Insurance
保柏 · 您的醫療保險專家

Claim Form No.
賠償申請表編號

Name of Subscriber / Employer : _____
投保人/僱主名稱

Name of Employee (For group contract only) : _____
僱員姓名（只適用於團體合約）

Name of Patient (If other than Subscriber / Employee) : _____
病人姓名（如非投保人或僱員）

Treatment Date : ____/____/____ (DD日 / MM月 / YY年)
診治日期

Total Receipt(s) Amount : _____
收據總額

Day Time Contact Tel. No. : _____
日間聯絡電話

Email Address : _____
電郵地址

Membership No. of Patient (16 Digits 位):
病人會員編號

Consultation 門診 : ○ General 普通科 ○ Specialist 專科 (Doctor's Referral letter to be attached 請連同醫生轉介信)

Post hospitalisation follow up visit : ○ Yes 是 ○ No 否
與住院治療有關之覆診

Date of hospitalisation: From ____/____/____ (DD日 / MM 月 / YY 年) to ____/____/____ (DD日 / MM 月 / YY 年)
住院日期 由 至

To be Completed by Member 由會員填寫

Since when the patient had these symptoms first appeared? 病人於何日首次出現上述症狀？ _____

Has the patient received any treatment for similar or related illness by other doctor(s) in the past? 病人曾否因同一或有關之病症而接受其他醫生的治療？

Yes 有 ○ No 無 ○ If Yes, please specify 如有，請詳述 _____

Treatment Date(s) 診治日期 _____ Name(s) , address and tel. no of the doctor(s) 醫生姓名、地址及電話號碼 _____

Are you making any other insurance or compensation claim as a result of this treatment? 有關是次治療，閣下有否申請其他賠償? ○ Yes 有 ○ No 無

If Yes, please specify the name of the Insurance Company / Organisation : _____
如有，請列明保險公司 / 機構名稱

Policy No. / Membership No.: _____
保單或會員編號

Return all original receipts after claim processing 賠償辦妥後需退回所有收據正本 ○ Yes 是 ○ No 否

Declaration & Authorisation 聲明及授權書

I hereby declare that the above information given is true and correct.
I further authorise any hospital, physician, insurance company or organisations that has any records or knowledge of me or my health to furnish such information to BUPA (Asia) Limited ("BUPA") 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 authorisation shall be considered as effective and valid as the original.
I understand that if I and / or the Member(s) fail to provide any information requested in this claim form, it may result in the inability of BUPA to accept or process this claim.
I understand that all Members' personal information collected or held by BUPA will be used for processing the claims, analysis or for providing any other insurance product or service; and such information may be transferred to any related company or an appointed agent / broker, if applicable, or any other company carrying on or related to insurance / reinsurance business or any association or federation of insurance company within or outside Hong Kong. I shall have the right to access and request correction of any personal information concerning the Member held by BUPA; and request for such access and correction can be made to the Data Privacy Officer of BUPA (Asia) Limited at Unit 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong.
本人謹此聲明，以上所填報之一切資料，均屬真確無訛。
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、診斷報告及藥方的資料給與保柏（亞洲）有限公司（"保柏"）。此授權書之影印本與正本具同等效力。
本人明白，如本人或會員未能就本賠償申請表所需提供足夠資料可能會導致保柏不能接受或處理本賠償申請。
本人明白凡保柏收集或持有之所有關於會員的個人資料將作為索償、分析用途，或作為提供任何其他保險產品或服務之用；而此等資料可能會被轉交本港或海外之任何提供有關服務之公司或獲委任之保險代理人 / 經紀（如適用者）、或任何其他經營保險 / 再保險業務有關之公司或任何保險業協會或聯會。本人將有權索閱及修正保柏所持有任何關於會員之個人資料；有關索閱及修正資料可致函保柏（亞洲）有限公司，香港鰂魚涌華蘭路25號大昌行商業中心18樓「個人資料主任」收。

Date 日期 _____

X _____
Signature of Member 會員簽署

Remarks: Before sending in this form , please read the Claims Procedures on reverse side of this claim form to expedite the process of your claim reimbursement.
備註：為加快處理閣下之索償申請，請於寄出此賠償申請表前先細閱背頁之索償程序。

OP/BCFC-CC/0105R12

BUPA Clinical Claim Form 保柏門診賠償申請表

Claims Procedures

Please check if you have done the following before claim submission:

1. Sign and complete this claim form.
2. Attach all original medical receipts and supporting reports.
3. Original receipts must clearly indicate the following information and be signed by the attending physician:
   - Treatment date
   - Name of patient
   - Diagnosis
   - Breakdown of charges
4. Attach referral letter provided by your General Practitioner for the claim of Specialist Consultation, Diagnostic X-ray and Laboratory Tests or Prescribed Medication. The referral letter is valid for same or related disability for a period of six months from date of issuance. Treatment received for a new or unrelated disability will require another referral letter.
5. Attach **Pre-authorisation confirmation,** if applicable.
6. Indicate in the claim form if you require us to return the original receipts(s).

No Reimbursement of claims shall be made for:

- Claim(s) submitted after 90 days from the date of treatment.
- Insufficiency of required information.

Please return this completed claim form with attachment(s) to:

BUPA (Asia) Limited - Claims Dept.
18/F, DCH Commercial Centre,
25 Westlands Road,
Quarry Bay, Hong Kong
Telephone : (852) 2517 5388
Facsimile : (852) 2548 1848
Website : www.bupa.com.hk

索償程序

在遞交賠償申請前，請檢查下列各項是否已辦妥：

1. 簽署及填妥此賠償申請表。
2. 附上所有醫療收據正本，及有關文件。
3. 收據正本必須清楚列明以下資料，並由主診醫生簽署：
   - 診治日期
   - 病人姓名
   - 病症
   - 收費項目說明
4. 如申請專科、X光檢驗及化驗費或處方西藥之賠償，請附上普通科醫生的轉介信。轉介信在發出日起計六個月內診治與該信有關之病症均為有效。而當診治病症被診斷為一新症，或診治與該轉介信無關之病症則須提交其他轉介信。
5. 如診治項目需**初步保障審核**，請附上**初步保障審核結果**。
6. 如需退回收據正本，請清楚註明於賠償申請表上。

根據以下情形，賠償申請將不獲辦理：

- 索償申請於治療日90天後遞交。
- 所需資料不足。

填妥之賠償申請表及附帶文件請交回：

保柏（亞洲）有限公司－賠償部收
香港鰂魚涌華蘭路25號
大昌行商業中心18樓
電　　話：(852) 2517 5388
圖文傳真：(852) 2548 1848
網　　址：www.bupa.com.hk