BUPA Hospital Claim Form 保栢住院賠償申請表

BUPA Health Insurance 保栢・您的醫療保險專家

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 Imaging and Laboratory Tests. 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 this claim form if you require us to return the original receipt(s).

No Reimbursement of Claims shall be made for:

- Claim(s) submitted after 90 days from the date of discharge.
- 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、診斷影像及化驗費之賠償，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：

- 索償申請於出院日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：

保栢（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

PART I – To be Completed by Member 第一部份 由會員填寫

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 : _____
病人名稱

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

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

Date of Birth : _____ Sex : _____
出生日期 性別

Date of Treatment : From _____ to _____
診治日期 由 DD 日 / MM 月 / YYYY 年 至 DD 日 / MM 月 / YYYY 年

Email Address : _____
電郵地址

If hospitalisation was due to illness 若因疾病而住院

1. Describe the symptoms and abnormalities which led to the hospitalisation
   請列出病人因何不適及有何症狀導致是次入院
2. Name , address and tel. no of doctor / hospital the patient first consulted for the illness
   初診醫生 / 醫院姓名、地址及電話
3. Date of the first consultation 初診日期
4. Since when had these symptoms first appeared? 病人於何日首次出現上述症狀?
5. Has the patient received any treatment for similar or related illness by other doctor(s) or admitted to hospital in the past? 病人曾否因同一或有關之病症而向其他醫生求診或入院?

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

   Treatment Date 診治日期 _____

   Name & address of the doctor(s) / hospital(s) 醫生 / 醫院姓名及地址

   Other information 其他資料 _____

If hospitalisation was due to accident 若因意外而住院

1. When did it happen? 意外發生日期?

   Date 日期 _____ Time 時間 _____
2. Where and how did it happen? 意外發生的地點及經過?
3. Injured area, type and severity of the injury. 受傷部份、類別及傷勢。
4. Did the patient report to the police? 傷者有否報警?

   Yes 有 ○ Send us a copy of the police report 請提交有關檔案副本一份 No 否 ○
5. Was there any concurrent / predisposing illness at the time of the accident?
   意外發生時，是否有其他已存在之疾病?
6. Other information 其他資料 _____

   Did you submit a claim for workmen's compensation? If yes, please specify the result.
   有關是次索償閣下有否申請勞工賠償，如有，請詳述結果?

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

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 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栢（亞洲）有限公司（"保栢"）。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栢不能接受或處理本賠償申請。
本人明白凡保栢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栢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栢（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

PART II – To be Completed by Attending Physician/Surgeon 第二部份 由主診醫生填寫

Name of Patient 病人姓名：_____ HKID Number 香港身份證：_____

Admission Date 入院日期：_____ Discharge Date 出院日期：_____

A. Clinical History 門診病歷

1. Date on which the patient first consulted you for the condition or related illness / injury which led to this hospitalisation / treatment / diagnostic tests?
   病人首次就上述病況或有關疾病或受傷，而導致是次住院 / 治療 / 診斷性化驗之求診日期？

2. What were the patient's chief symptom(s) / complaint(s) for this hospitalisation / treatment / diagnostic tests? 病人是次主要因何徵狀或申訴入院、接受治療或診斷性化驗?

3. How long had the patient been experiencing these symptoms before the first consultation? 在病人首次求診前，該傷病已患有多長時間?

4. What was your clinical diagnosis and when was it made? 您是何時對病者作出診斷？請列出您診斷的內容。

B. Hospitalisation History 住院病歷

Final diagnosis 病症結果：_____ Operation performed 手術名稱：_____

Date of Operation 手術日期：_____ Surgeon / Assistant Surgeon name 外科醫生 / 助理外科醫生姓名：_____

Recommended treatment & the reason for the treatment 轉介之治療名稱及原因

Recommended diagnostic tests & the reason for the tests 轉介之診斷性化驗名稱及原因

1. If you have referred other doctor to the patient during the hospitalisation, please provide the following relevant information. 於住院期間，如閣下已將病人轉介往其他醫生，請提供下列有關資料。

Referred doctor name 醫生姓名	*Referral reason 轉介原因*	*What treatment the doctor performed 治療名稱*

2. Brief discharge summary (including onset & duration of sign & symptoms / disease, etiology, types & results of major examination, treatment, complication & follow up plan).
   出院撮要：（請列出有關病及病徵的病發日期、病因、檢驗性質與結果、有關治療、併發症及跟進計劃。）

3. Has the patient taken any home leave during this hospitalisation? 於住院期間，病人有否請假外出？
   No 無 ○ Yes 有 ○ Please state the date, time and reason 請列明日期、時間及原因

Remarks: Please attach copies of histopathology, endoscopic, diagnostic / laboratory tests report, operating theatre summary 備註：請連同病理學、內視鏡、診斷性化驗 / 檢驗報告、手術室撮要副本交回。

C. Professional Comment 專業意見

1. In your opinion, was the hospitalised illness a recurrent episode or a chronic disease? If so, when would be the first episode?
   就閣下意見，是次病況是否為復發性病症或慢性病症？如是，何時為首次復發日期？

2. Has the patient ever had the same or similar symptoms(s) before? 病人以前曾否患有同類病況？
   No 無 ○ Yes 有 ○ Please state when and describe details 請說明日期及詳情

3. Was the condition due to or associated with the following (circle the right answers) 上述情況是否因以下問題所致?（請圈出正確答案）

   accidental bodily injury \ the abuse of drugs or alcohol \ AIDS / HIV related illness, veneral disease or sexually transmitted disease \ pregnancy, infertility or sterilization \ refractive error \ cosmetic or plastic surgery \ mental or nervous disorder \ congenital condition \ hereditary condition \ developmental condition \self inflicted injury \ general check up or vaccination \ **NONE OF THE ABOVE**
   身體意外受傷 \ 濫用藥物或酒精 \ 後天免疫力缺乏症（愛滋病）/ 與人類免疫力缺乏病毒（HIV）、性病或因性接觸感染之疾病 \ 懷孕、不育或絕育 \ 視力不正常 \ 美容或整容手術 \ 精神或神經病 \ 先天性症狀 \ 遺傳性疾病 \ 發育異常 \ 自我傷害 \ 一般身體檢查或防疫注射 \ **以上全部不對**

4. Had the patient been previously treated or hospitalised for this or any other disorders? If so, please give a brief summary (including onset & duration of sign & symptoms / disease; etiology; type & results of major examination; treatment & follow up results) 病者過去曾否就此病或其他病症而需接受診治或入院接受治療？如是者，請說明撮要（請列出有關病況及病徵的病發及痊愈日期、病因、檢驗性質與結果、有關治療、併發症及跟進計劃。）

Dates 日期	Disease / Disorder / Complaint 疾病 / 失調 / 申訴	Details of treatment / hospitalisation 治療 / 住院的詳情	Name of doctor / hospital 醫生 / 醫院名稱

(Please use any separate paper with the doctor's signature on it if more space is needed) 若需另頁填寫，每張紙都須有醫生的簽署作實

D. Others 其他

1. Are you the patient's usual physician? 閣下是否病者的長期醫生?
   i. Yes ○, please fill in question 2 是，請填寫問題 2
   ii. No ○, Does the patient have any other usual/family doctor(s)? if Yes, please give us the name(s) and telephone no. _____
   不是，病人是否有其他的長期 / 家庭醫生？如是，請提供姓名及電話號碼

2. Please fill in the date of consultation and the symptoms and complaints of the patient for each consultation 請填寫診治日期及每次診治的病徵及申訴

Consultation date 診治日期	Symptoms / Complaints 病徵 / 申訴	Recommended tests / treatment 已轉介的檢查或治療

3. 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。

Surgeon / Attending Physician 請提供主診醫生資料

Name of Doctor 醫生姓名：_____ Telephone 電話：_____ Email Address 電郵地址：_____

Address 地址：_____

Signature & Chop of Surgeon / Attending Physician **主診醫生簽署及蓋章**	**Authorised Signature & Chop of Hospital** **醫院授權簽署及蓋章**
X	**X**
Date: **日期**	**Date:** **日期**