Blue Cross 藍十字

An AIA Company 友邦保險成員公司

收集個人資料聲明
Personal Information Collection Statement

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HOSPITALISATION & SURGICAL CLAIM FORM
住院及手術索償申請表

Enjoy Speedy Claim Submission via eClaim in 3 simple steps

1. Input claim details
2. Upload the scanned copies/photos of receipt
3. Confirm

透過電子索償平台簡單 3 步遞交索償申請

1. 輸入索償資料
2. 上載收據之掃瞄副本 / 相片
3. 確認

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Blue Cross HK App

Claim Notes

1. This form is applicable to hospitalisation and day case surgery in hospital/clinic claims.
2. You can find the Policy number and Insured number on Blue Cross Certificate of Insurance or Blue Cross Healthcare Card, you may also visit www.bluecross.com.hk/supercare to view account information after logging in.
3. Please print this claim form on A4 size paper and send it together with the original receipts to Medical Claims Department of Blue Cross (Asia-Pacific) Insurance Limited ("The Company") within 90 days from treatment date or discharge date. The Company's Personal Information Collection Statement as accompanied with this form is for your reference and retention, please do not return it along with your claim application.
4. The Company is entitled to request for your provision of further information and documents or completion of other specific claim forms.

索償注意事項

1. 此申請表適用於住院及醫院 / 門診日症手術索償。
2. 您可於藍十字保險證明書或藍十字醫療卡上查看保單號碼及受保人號碼，您亦可登入 www.bluecross.com.hk/supercare 查閱賬戶資料。
3. 請以 A4 紙打印此索償申請表，並於治療或出院後 90 天內，連同收據正本一併交回藍十字（亞太）保險有限公司（「本公司」）醫療保險理賠部。隨本申請表附上的收集個人資料聲明，是供閣下參閱及保留之用，請無需於提交索償申請時退回。
4. 本公司有權要求閣下提供更多資料及文件或填寫其他專用索償表格。

Claim Instructions

1. Complete and sign this form and attach the **original** receipts issued by the doctor and/or hospital or certified true copy of receipts issued by other insurers (if applicable). Each receipt **MUST** state the following information:
   - Full name of patient
   - Date of treatment
   - Diagnosis
   - Breakdown of charges
   - Doctor's signature and official stamp
   - Name of surgery (if applicable)
2. For confinement in the general ward of government hospital, please attach the original receipts issued by the hospital together with a copy of discharge summary. If no diagnosis is provided by the doctor, the insured (patient) is required to supplement the exact diagnosis (e.g. Hypertension) on the above mentioned documents and confirm with a signatory.
3. Provide copy of claim settlement advice from other insurers, if applicable.
4. Original receipt will not be returned once submitted. Please tick the appropriate box if certified true copy of receipt is required.

索償申請指示

1. 填妥此申請表及簽署，並附上由醫生及 / 或醫院簽發的收據正本或由其他保險公司發出的收據核實副本（如適用）。每張收據正本必須列明以下項目：
   - 病人姓名
   - 治療日期
   - 病症名稱
   - 收費項目說明
   - 醫生簽署及蓋章
   - 手術名稱（如適用）
2. 若入住政府醫院普通病房，請提供由政府醫院發出的收據正本及出院撮要副本。若醫生未有註明病症名稱，受保人（病人）須於上述文件上補充確實的病症名稱（例如：高血壓）並簽署確認。
3. 如適用，請提供其他保險公司之賠償結算通知書副本。
4. 一經遞交之收據正本將不獲發還。如需索取收據之核實副本，請於適當空格內畫上「✓」號。

Part I 甲部 – To be completed by the Insured (Patient) 由受保人（病人）填寫

（or his/her parent if the Insured is aged below 18 若受保人之年齡在 18 歲以下，請由其家長填寫）

To avoid delay in processing your claim due to incomplete information, please complete all the below information in English BLOCK letters.
為免因資料不全而延遲處理閣下之索償申請，請以英文正楷填妥下列所有資料。

Name of Policyholder/Employer 保單持有人姓名 / 僱主名稱	Policy No. 保單號碼	Staff No. (if applicable) 職員編號（如適用）
Name of Employee in English (if applicable) 僱員之英文姓名（如適用）	Employee's Insured No. (if applicable) 僱員之受保人號碼（如適用） |__|__|__|__|	HKID Card No. 香港身份證號碼
Name of Insured (Patient) in English 受保人（病人）之英文姓名	Patient's Insured No. (must be provided) 病人之受保人號碼（必須提供） |__|__|__|__| - |__|__|__|__|	HKID Card No. 香港身份證號碼

☐ Original receipt will not be returned once submitted. Please put a "✓" in this box for request of certified true copy of receipt for other insurance claims.
一經遞交之收據正本將不獲發還。如需索取收據之核實副本辦理其他保險索償，請於方格內畫上「✓」號。

1. Admission/Day Case Surgery Date 入院/日症手術日期（DD/MM/YY 日 / 月 / 年）________ Discharge Date 出院日期（DD/MM/YY 日 / 月 / 年）________
2. Have you ever had any prior treatment(s) for this diagnosis or related conditions? 閣下有否曾因同一診斷或相關病況而接受治療？ ☐ Yes 是 ☐ No 否
   Date(s) 日期（DD/MM/YY 日 / 月 / 年）________ Name of Doctor(s) 醫生姓名 ________ Contact No. 聯絡電話 ________
3. Have you ever made any other insurance or compensation claim(s) resulting from this treatment? ☐ Yes 是 ☐ No 否
   有關此次治療，閣下有否曾經申請其他保險 / 機構賠償？
   Are you going to make any other insurance or compensation claim(s) resulting from this treatment? ☐ Yes 是 ☐ No 否
   有關此次治療，閣下是否將會申請其他保險 / 機構賠償？
   If yes, please provide 如是請提供
   (i) Name of Insurance Company 保險公司名稱 ________ (ii) Policy No. 保單號碼 ________
   (iii) Type of Insurance Product 保險產品類別 (applicable to Insured under Caring Medical Protection Plus 只適用於「摯安心精選」醫療保險計劃之受保人)
   ☐ Group Medical Insurance 團體醫療保險 ☐ Individual Medical Insurance 個人醫療保險 ☐ Others 其他
4. Was the treatment a result of an accident? 此次治療是否由於一宗意外引致？ ☐ Yes 是 ☐ No 否
   Date 日期（DD/MM/YY 日 / 月 / 年）________ Time 時間 ________ Place 地點 ________
   Brief Description 經過 ________

Declaration and Authorisation 聲明及授權書

1. I/We have obtained all necessary authorisation from my/our dependents (if applicable) to supply their information to Blue Cross (Asia-Pacific) Insurance Limited ("the Company") or its authorised representative if my/our dependents are parties to the claim request(s). I/We also understand that the information requested in this form is required in order for the Company to process these claims.
2. I/We hereby authorise any hospital, physician, medical practitioner, medically related service provider, insurance company, person, party and/or authority that has any records or is holding any information of the insured person or me/us to disclose to the Company or its authorised representative, any and all information with respect to the insured person's or my/our loss, disability, claim history, medical history, police statement made and the like for the purpose of assessing the insured person's or my/our claim request(s). A photocopy of this authorisation shall have the same effect as the original.
3. I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.
4. I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.
5. I/we agree and understand that the claims' information (including but not limited to submitted medical records) may be disclosed to the Employee's Insured.

1. 如本人 / 我們之家屬為賠償申請之一方，本人 / 我們已向家屬取得一切所需授權（如適用），向藍十字（亞太）保險有限公司（「貴公司」）或其授權代表提供其個人資料。本人 / 我們亦明白本表內所提供的資料是讓貴公司作處理本人 / 我們索償之用。
2. 本人 / 我們謹此授權任何持有受保人或本人 / 我們之任何記錄或資料的醫院、醫生、醫學界執業人士、與醫療有關的服務供應商、保險公司、有關人士、機構、及 / 或有關當局，向貴公司或其授權代表提供任何或所有有關受保人或本人 / 我們之損失、損傷、賠償記錄、病歷、口供或任何相關資料作評估受保人或本人 / 我們的賠償申請之用途。此授權書之正本及副本皆具同等效力。
3. 本人 / 我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此賠償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人 / 我們明白發出或填妥此賠償表格並不代表貴公司確認責任或保證賠償。
4. 本人 / 我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。
5. 本人 / 我們同意並理解，索償的資料（包括但不限於已提交的醫療記錄）可能會提供給僱員之受保人。

________________ ________________
Signature of Insured (Patient) 受保人（病人）簽署 Date 日期（DD/MM/YY 日 / 月 / 年）

In the event of the patient aged below 18, this form should be signed by his/her parent. 倘若病人之年齡在 18 歲以下，本申請表須由其家長簽署。

Part II – To be completed by the attending physician/surgeon at the claimant's own expenses
乙部 – 由主診醫生／外科醫生填寫，所需費用由索償人自行承擔

Full Name of Patient (please fill in English BLOCK letters) 病人全名（請以英文正楷填寫）：

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

Name of Hospital 醫院名稱：

Level of hospital ward 病房級別： ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 普通房 ☐ Clinical Surgery 門診小手術

1. Clinical History 求診記錄

a) When did the patient first consult 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/MM/YY 日／月／年）：

b) Symptom(s)/complaint(s) of the patient relating to this hospitalisation/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？

d) When did you refer the patient for hospitalisation? 閣下轉介病人入院的日期（DD/MM/YY 日／月／年）：

2. Details of Hospitalisation 住院詳情

a) Final Diagnosis 最後的診斷：

b) Etiology of disease 病因： c) Date of Operation 手術日期（DD/MM/YY 日／月／年）：

d) Operation procedure(s) performed 手術名稱：

e) If the patient had consulted other physician(s) during this hospitalisation, 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：

f) Had the patient taken any home leave during the hospitalisation? 病人住院期間有否請假外出？ ☐ Yes 有 ☐ No 沒有

If yes, please state the date, time and reason for home leave 如有，請列明外出的日期、時間及原因

g) 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）:

h) Please provide reason(s) for hospitalisation if this type of cases can be managed on day care/outpatient 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：

3. Professional Comment 專業意見

a) In your opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint/diagnosis. 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？ ☐ Yes 是 ☐ No 否

If "yes", please provide date of the first episode and details. 若答案為「是」者，請提供首次發病日期及詳情：

b) Was the condition due to or associated with the following？上述情況是否出於或與以下問題關連？ ☐ Yes 是 ☐ No 否

If "yes", please tick the appropriate boxes 若答案為「是」者，請在適當空格填上✓號

☐ Accidental bodily injury 意外身體受傷
☐ Pregnancy 懷孕
☐ Congenital condition 先天性疾病／異常
☐ Self-inflicted injury 自我傷害
☐ Infertility or sterilization 不育或絕育
☐ Developmental condition 發育問題
☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Contraception 避孕
☐ Hereditary condition 遺傳性問題
☐ Mental disorder 精神紊亂
☐ Treatment for cosmetic purpose 美容性質的治療
☐ General checkup 一般身體檢查
☐ Refractive error 屈光不正
☐ Vaccination 疫苗接種
☐ 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
☐ Others 其他：

4. Others 其他

a) If the patient was referred by another doctor, please provide the name and address of the referring doctor. 如病人由其他醫生轉介，請提供轉介醫生的姓名和地址：

b) Are you the patient's usual physician? 閣下是否此病人的慣常醫生？ ☐ Yes 是 ☐ No 否

I hereby certify that all information given above is accurate, true and complete and are given to the best of my knowledge.
本人謹此聲明，就本人所知，上述所提供的所有資料均是準確無誤、真實及為事實之全部。

Signature and official stamp of attending physician/surgeon 主診醫生／外科醫生簽署及蓋章

Address and Telephone No. 地址及電話號碼

Name of attending physician/surgeon and qualifications 主診醫生／外科醫生姓名及資歷

Date 日期（DD/MM/YY 日／月／年）

Note: Part II of this claim form is drafted by the Hong Kong Medical Association and Medical Insurance Association of The Hong Kong Federation of Insurers, and subsequently revised by Blue Cross (Asia-Pacific) Insurance Limited.

備註：本索償申請表乙部由香港醫學會及香港保險業聯會屬下醫療保險協會提供初稿，後經藍十字（亞太）保險有限公司修訂。