API 亞太財險 Asia-Pacific P&C

醫療保險 (入院 / 日間手術) 索償表格
IN – PATIENT / DAY SURGERY MEDICAL CLAIM FORM

請回答此表格上所有問題; 發出此表格並不代表本公司已承認責任。
All questions must be answered; no liability is admitted by issuing this form.

本公司專用 Office Use
賠案編號 Claim No. _____

索賠遞交
請郵寄索賠文件到以下地址:
香港干諾道中148號粵海投資大廈23樓
亞太財產保險有限公司 - 香港分公司

Claim submission
Please mail the claim document to the below address:
23/F, Guangdong Investment Tower, 148 Connaught Road Central, Hong Kong
Asia-Pacific Property & Casualty Insurance Company Limited- HK Branch

第一部份由受保人填寫 Part I – Completed by Insured

1. 受保人資料 INSURED DETAILS

僱主 / 團體名稱 Name of Employer / Policyholder		受保僱員 Name of Employee	
保單編號 Policy No.		受保證明書 / 職員編號 Certificate / Staff No.	
病人姓名 Name of Patient		與受保僱員之關係 Relationship to Employee	
日間聯絡電話 Daytime Contact No.		電郵 Email	

有關是次治療, 閣下有否申請其它賠償? ☐ 有 / ☐ 否
如有, 請提供該保險公司 / 機構名稱: _____
有關保單號碼或會員編號: _____
Do you have any other insurance or compensation claim as a result of this treatment? ☐ Yes / ☐ No
If yes, please specify name of such Insurance Company / Organization: _____
Policy Number / Membership Number: _____

2. 退還文件的核實副本 REQUEST FOR CERTIFIED TRUE COPY OF SUPPORTING DOCUMENT(S)

☐ 正本文件包括收據並不會退還。 如欲索取正本文件的核實副本, 請在空格內填上「✓」號。

☐ The original supporting document(s) including receipt(s) will not be returned Please "✓" this box if you want a certified true copy of original supporting document(s).

索賠遞交 Claim Submission

填妥索償申請表後, 請連同所需文件郵寄至索償表格上方所列的郵寄地址。

Completed this claim form, please submit it together with supporting documents to the mailing address stated at the top right of the claim form.

3. 醫療狀況 MEDICAL CONDITIONS

根據以下情形, 索償申請將不獲辦理:

- 索償申請表於求診 / 治療日 90 日後遞交
- 所需資料不足 本索償將會以您之保單內容及保單條款為準。

No reimbursement of claims shall be made for:

- Claims(s) submitted after 90 days from the date of consultation/treatment
- Insufficiency of required information Please note that the final decision on the claim(s) will be subject to policy coverage, terms and conditions.

首次診症 First Consultation	醫生姓名 Name of Doctor			
	首次求診日期 (DD/MM/YY) Date of First Consultation	/ /	首次出現病微的日期 (DD/MM/YY) 1st Date of Symptoms Noticed	/ /
	病況描述 Description of Sickness			

您有否曾因同一或相關病況而接受治療? (如適用)
Have you had any prior treatment for this or related conditions? (If applicable)
☐ 有 (請填寫醫生資料) Yes (Please fill in doctor info)
☐ 否 (請填寫餘下部份) No (Please fill in the rest)

醫生姓名 Name of Doctor		診所或醫院地址 Address of Clinic or Hospital	
如治療與懷孕相關, 請提供預產期 (如適用)。 If treatment is due to pregnancy, please give expected date of delivery (if applicable).		/ / (DD/MM/YY)	

4. 收集個人資料聲明 PERSONAL INFORMATION COLLECTION STATEMENT

閣下提供的資料，為本公司提供保險業務所需，並可能使用於任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消、續期、索償或索償分析；及可能移轉給現存或不時成立的任何與我們有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，或任何保險公司的協會或聯會。閣下有權要求查閱及更正由亞太財產保險有限公司-香港分公司持有之閣下的個人資料，如有此項要求，請與我們的個人資料主任聯絡。

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of any insurance or financial related product or service or any alterations, variation, cancellation or renewal of them and any claim or analysis of it; and may be transferred to any of our related companies or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time. You have the right to obtain access to and to request correction of any personal information concerning yourself held by Asia-Pacific Property & Casualty Insurance Company Limited – Hong Kong Branch Requests for such access can be made to our Data Protection Officer.

5. 所需文件指引 DOCUMENT CHECKLIST

必需提供的基本資料 Basic Info must be submitted	□ 由您及您的主診醫生填寫的索償申請表 □ 醫療費用收據正本 (包括按金收據) □ 顯示醫院收費細目之醫院賬單副本 (包括每日收費、膳食費用及套餐費) □ 提供其他保險公司之賠償結算通知，如適用	□ Claim form completed by yourself and your attending doctor □ Original payment receipt(s) of medical expenses (including deposit receipt) □ Copies of statement for breakdown of hospital expenses (including daily charges, meal charges and package charges) □ Settlement advice from other insurer, if any
附加資料 (如適用) Other Info (If applicable)	□ 出院撮要 (如入住香港醫管局轄下公立醫院之普通病房，出院撮要可替代索償申請表之第二部分) □ 化驗費細目 □ 藥物清單(包括藥名、劑量、數量及費用) □ 病理學、內窺鏡、診斷性化驗/ 檢驗之文字報告及手術室撮要副本(X 光片、超聲波照片等不用遞交) □ 住院/ 手術套餐費細目，如適用 □ 專科醫生轉介信副本	□ Discharge summary (If the patient is confined in ward level of government hospital that managed by Hospital Authority, the discharge summary would replace Part II of this claim form) □ Laboratory test breakdown □ Drug list (include drug name, dosage, quantity and amount) □ Copies of histopathology, endoscopic, diagnostic/laboratory tests written report, operating theatre summary (X-ray film, ultrasound photo are not required) □ Hospitalisation/Surgical package charges breakdown, if any □ Referral letter(s) for any specialists

6. 聲明及授權 DECLARATION AND AUTHORIZATION

本人現聲明上述所填報的資料均屬真實、正確及完整。本人在此授權任何持有本人資料或健康紀錄之醫院、醫生、保險公司或機構，可以將部份或全部有關本人傷病之病歷，診斷報告、藥方或治療及所有醫院或醫療紀錄副本給與**亞太財產保險有限公司-香港分公司** 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 all of the above information given is true, correct and complete. I hereby authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish **Asia-Pacific Property & Casualty Insurance Company Limited – Hong Kong Branch** or its authorized representative with any or all information with respect to any illness, 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.

索償人簽署 Signature of Claimant	病人簽署 Signature of Patient	日期 Date

第二部份由主診醫生填寫 Part II – Completed by Attending Doctor

1. 一般資料及病歷 GENERAL INFO AND CLINICAL HISTORY

病者姓名 Patient Name		醫院名稱 Name of Hospital		
入院日期 (DD/MM/YY) Date of Admission		出院日期 (DD/MM/YY) Date of Discharge		
病房級別 Level of Ward	□ 門診手術 Clinical Surgery	□ 頭等房 Private	□ 二等房 Semi-Private	□ 三等房 Ward
首次看診日期 (DD/MM/YY) Date of First Consultation for This Condition				
首次看診時的病徵 Symptoms Presented During First Consultation				
相關病徵在病者看診前的持續時間 How Long Had the Patient Been Experiencing These Symptoms Before the First Consultation				

2. 住院詳情 DETAILS OF HOSPITALIZATION

手術日期 (DD/MM/YY) Surgical Date		手術名稱 Name of Operation	
最後診斷 Final Diagnosis			
病者的治療/ 檢查是否可在門診進行？ Is it possible that the treatments/investigations of the patient be managed on an out-patient basis?	□ 可以 Yes 是次住院原因 Reason for this admission: _____ □ 不可以 No 原因 Reason: _____		

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

醫生姓名 Name of Physician		原因 Reason	
治療詳情及結果 Treatment Details and Result			

3. 專業意見 PERFESSIONAL INSIGHTS

您認為是次住院是因為複發性/ 長期疾病或之前的疾病/ 意外? 如"是"，請提供日期和說明細節
Was the hospitalization a result of recurrent episode/chronic illness or related to a previous condition in your view? If "yes", please provide dates and details.

上述情況是否與以下問題有關? Was the condition due to or associated with the following?

□ 意外身體受傷 Accidental bodily injury	□ 精神紊亂Mental disorder	□ 不育或絕育 Infertility or sterilization
□ 發育問題 Developmental condition	□ 屈光不正 Refractive error	□ 濫用藥物或酒精 Abuse of drugs or alcohol
□ 先天性疾病/異常 Congenital condition	□ 疫苗接種 Vaccination	□ 美容性質的治療 Treatment for cosmetic purpose
□ 避孕 Contraception	□ 自我傷害 Self-inflicted injury	□ 性病，性傳播疾病或愛滋病/愛滋病毒有關的疾病
□ 一般身體檢查 General check-up	□ 懷孕 Pregnancy	Venereal disease , sexually transmitted disease or AIDS/HIV related illness

閣下是否該病者的慣常醫生？ Are you the patient's usual physician?	☐ 是 Yes ☐ 否 No	轉介醫生姓名及地址,如適用 Referring Doctor Name and Address, if applicable

4. 主診醫生聲明及授權 DECLARATION AND AUTHORISATION FROM ATTENDING DOCTOR

本人特此聲明，就本人所知，上述所有資料均準確無誤。 I hereby certify all information given above is accurate and true to the best of my knowledge.	主診醫生/ 外科醫生簽名或蓋章 Signature or Official Stamp of Attending Physician/Surgeon	日期 Date (DD/MM/YY)
	主診醫生/ 外科醫生姓名 Name of Attending Physician / Surgeon	