Bupa Clinical Claim Form 保柏門診賠償申請表

Only completed original claim form is accepted 只接受已填妥之賠償申請表正本

Claim Form No.
賠償申請表編號

Name of Subscriber / Employer 投保人 / 僱主名稱：_____ Day Time Contact Tel. No. 日間聯絡電話：_____

Name of Employee (for group contract only) 僱員姓名（只適用於團體合約）：_____ Date of Birth 出生日期：_____

Name of Patient (if other than Subscriber / Employee) 病人姓名（如非投保人或僱員）：_____ Email Address 電郵地址：_____

To be completed by Member 由會員填寫

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

Please fill in the nature of claims and breakdown of charges 請填上索償性質及各項收費

No. 序號	Date of treatment 診治日期 DD日 / MM月 / YY年	Nature of Reimbursement 索償性質 (Please put a "✓" in the appropriate box 請在適用的方格內加上 "✓")						Amount indicated on the receipt 收據金額	Since when the patient had these symptoms first appeared? 病人於何日首次出現有關症狀？
		GP 普通科醫生	Specialist * 專科醫生	Physiotherapy / * Chiropractic 物理治療 / 脊醫治療	Diagnostic * Imaging & Lab tests 診斷影像及化驗	Chinese # Herbalist / Bonesetter 中醫 / 跌打	Other (pls. specify) 其他 (請註明)		
1.									
2.									
3.									

* Please attach doctor's referral letter 請連同醫生轉介信遞交　　# Please attach Chinese Medicine prescription 請連同中藥藥方遞交

Post hospitalisation follow up visit 出院後之跟進覆診： ○ Yes 是 ○ No 否　　Date of hospitalisation 住院日期：From 由 DD日 MM月 YY年 to 至 DD日 MM月 YY年

Have you ever made or will you make any claim request for compensation from any organisation as a result of this treatment? 就有關治療，您曾否或將會向任何機構要求賠償？ ○ 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 _____

Please tick "Yes" for return of certified true copy of receipt 如需取回收據的核實副本，請於"是"加上"✓" ○ Yes 是 ○ No 否

Declaration and Authorisation 聲明及授權書

I hereby declare that the above information given is true and correct.
I also authorise any medical practitioner, hospital, clinic, by whom or where I and/or the Member(s) have been observed or treated or any insurance company or organisation that has any records or health information concerning me and /or the Member(s) for any reason, to give full particulars thereof including prior medical history to Bupa. A 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 my and / or the Members' personal information collected or held by Bupa is provided and may be held, used, and disclosed by Bupa or individuals / organisations associated with Bupa, appointed agent / broker, if applicable, or any selected third party (within or outside of Hong Kong, including reinsurance and claims investigation companies and industry associations / federations) for the purposes of processing this claims application and providing subsequent services and claims analysis or providing any other insurance products and services, direct marketing, and data matching, and to communicate with me for such purposes. I shall have the right to access and request correction of any personal information concerning me and / or the Member(s) held by Bupa; and request for such access and correction can be made to the Personal Data Privacy Officer of Bupa 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。
本人並且授權任何為本人及 / 或會員觀察或治療的醫生、醫院、診所，或持有本人及 / 或會員健康或任何資料之保險公司或機構將本人及 / 或會員之全部資料（包括病歷）呈交予保柏。本授權書之副本與正本具有同等效力。
本人明白，如本人及 / 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。
本人明白保柏可保留、使用或透露保柏所收集或持有之所有關於本人及 / 或會員的個人資料，及給予與保柏有關的人士 / 機構、獲委任之保險代理人 / 經紀（如適用）或任何被揀選的第三者（在香港境內或境外，包括再保險及賠償調查公司，及有關的行業協會或聯會），用作處理本賠償申請及索償分析用途或提供售後服務或任何其他保險產品及服務、直接促銷及資料核對等用途，及因此等用途與本人聯絡。本人將有權索閱及修正保柏所持有任何關於本人及 / 或會員的個人資料；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「個人資料私隱主任」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 form to expedite the process of your claim reimbursement. 備註：為加快處理閣下之賠償申請，請於交回此賠償申請表前先細閱背頁之索償程序。

OP/BCFC-CC/0508-200K

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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 / stamped by the attending physician:
   - Treatment date
   - Name of patient
   - Diagnosis
   - Breakdown of charges
4. Attach referral letter provided by your Medical Practitioner for the claim of Specialist Consultation, Diagnostic Imaging and Laboratory Tests or Prescribed Medication. A referral letter is only valid for the same or related condition for a period of six (6) months from the date of issuance. Treatment received for a new or unrelated condition will require another referral letter.
5. Attach **Pre-authorisation confirmation**, if applicable.
6. Please indicate in the claim form if you require us to return the certified true copy of receipt(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 send 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
Customer Care helpdesk :
- Individual members (852) 2517 5333
- Group members (852) 2517 5388
- Bupa Gold members (852) 2517 5383

Facsimile : (852) 2548 1848
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 / 蓋印：
   - 診治日期
   - 病人姓名
   - 病症
   - 各收費項目
4. 如申請專科、診斷影像及化驗或處方西藥之賠償，請附上醫生轉介信。轉介信在發出後六個月內診治與該信有關之病症，方為有效。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，則需另一轉介信。
5. 如診治項目需**初步保障審核**，請附上**初步保障審核確認**。
6. 如需退回收據的核實副本，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：

- 賠償申請表於治療日90天後遞交
- 所需資料不足

填妥之賠償申請表連同附帶文件請交回：

保柏 (亞洲) 有限公司一理賠部收

香港鰂魚涌華蘭路25號
大昌行商業中心18樓
客戶服務專線：
- 個人計劃會員 (852) 2517 5333
- 團體計劃會員 (852) 2517 5388
- 保柏尊貴寶會員 (852) 2517 5383

傳真：(852) 2548 1848
www.bupa.com.hk