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醫療保險 – 住院及手術
MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL

本表格適用於住院或門診手術賠償

This form is applicable to both inpatient and outpatient surgical claim

PART I - TO BE COMPLETED BY THE PATIENT

保單持有人 / 僱主名稱 Name of Policy Holder/Employer		
僱員 / 成員姓名 Name of Employee/Member (For group insurance policy only)		保單編號 Policy No.
保戶編號(倘適用) Insured No./Certificate No. (If applicable)		
病人姓名 Name of Patient		身份證號碼 I.D. Card No.
職業 Occupation	出生日期 Date of Birth	性別 Sex <input type="checkbox"/> 男 M <input type="checkbox"/> 女 F
與保單持有人關係 Relationship to the Policy Holder		
<input type="checkbox"/> 本人 Self <input type="checkbox"/> 配偶 Spouse <input type="checkbox"/> 子女 Child <input type="checkbox"/> 僱員 / 成員 Staff/Member <input type="checkbox"/> 僱員 / 成員家屬 Dependent		
(1) 閣下是否曾因同一病況而接受治療? Have you had any prior treatment for this or related conditions? <input type="checkbox"/> 沒有 NO <input type="checkbox"/> 有 YES		
醫生姓名 Doctor's Name _____		
地址 Address _____		
日期 Date(s) _____		
(2) 有關此次住院 / 手術，閣下有否申請其他保險賠償? Are you making any other insurance claim as a result of this hospitalization/surgery? <input type="checkbox"/> 沒有 NO <input type="checkbox"/> 有 YES		
保險公司名稱 Name of Insurance Company _____		
保單號碼 Policy No. _____		
(3) 此次住院 / 手術是否由於一宗意外引致? Was the hospitalization/surgery a result of an accident? <input type="checkbox"/> 不是 NO <input type="checkbox"/> 是 YES		
日期 Date _____	時間 Time _____	地點 Place _____
經過 Brief Description _____		
<p>聲明及授權書 DECLARATION & AUTHORIZATION</p> <p>本人現聲明上述所填報的資料正確無訛。 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、診斷報告及藥方等資料給與亞洲保險有限公司或其代理人。此授權書之影印本與正本具同等效力。 I hereby declare that the above information given is true and correct. I further authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to ASIA INSURANCE CO., LTD. or its authorized representative, any 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 authorization shall be considered as effective and valid as the original.</p>		
日期 Date _____		病人簽署 Signature of Patient _____

PART II - TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSE

(1) 病人姓名 Name of Patient _____	
(2) 住院 Hospitalization 醫院名稱 Name of hospital _____ 入院日期 Date of Admission _____ 出院日期 Date of Discharge _____	
(3) 手術 Surgical procedure 手術日期 Date of operation _____ 手術名稱 Name of the procedure _____ 性質 Nature _____	
(4) 此次住院 / 手術的主要病因 Chief complaints of the patient relating to this hospitalization/surgery _____	
(5) 診斷 Diagnosis of conditions _____	
(6) 出院撮要 (治療及以後治療計劃, 包括診查辦法、結果、併發症及跟進計劃) Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow up plan) _____	
(7) 首次出現病徵日期或意外發生日期 Date of the accident occurred or symptom first appeared _____	
(8) 病人首次求診日期 Date of first consultation for this condition or related illness _____	
(9) 據閣下所知, 病人以前曾否患有同類病況? To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? <input type="checkbox"/> 沒有 NO <input type="checkbox"/> 有 YES 請說明何時及當時情況 Please state dates and describe _____	
(10) 病人是否經其他醫生轉介? Is the patient referred by another doctor? <input type="checkbox"/> 不是 NO <input type="checkbox"/> 是 YES 轉介醫生的姓名和地址 Name and address of the referral doctor _____	
主診/專科醫生的姓名(資歷) Name of Attending Physician / Specialist (with qualifications)	地址 Address
	電話 Telephone
主診/專科醫生簽名 Signature of Attending Physician / Specialist	日期 Date