請掃二條碼登入客戶專頁，隨時提交索償申請及查閱進度。
https://cs.chinalife.com.hk

中國人壽 CHINA LIFE | 海外

「國壽海外」尊尚醫療醫院直付預先批核申請表
MASTERCARE MEDICAL PLAN DIRECT BILLING PRE-APPROVAL FORM

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單編號 Policy No.

受保人身份證/ 護照號碼 I.D. / Passport No. of Insured

保險中介人資料 INSURANCE INTERMEDIARY INFORMATION

保險中介人姓名 Name of Insurance Intermediary

保險中介人編號 Insurance Intermediary Code

聯絡電話 Contact No.

重要須知 IMPORTANT NOTE

- 請受保人填妥此表格第一部份，及主診醫生填妥第二部份，並於入院前最少 7 個工作天（適用於香港住院）或 14 個工作天（適用於澳門、中國內地或海外住院），以傳真(852)2325 4833 或電郵 claimspa@chinalife.com.hk 方式遞交至「國壽海外」尊尚醫療保險顧客服務部。如有任何緊急查詢，請致電「國壽海外」尊尚醫療客戶專線(852) 3999 5501 與客戶服務員聯絡。在審核受保人符合本預先批核申請的情況下，本公司將委任國際救援(香港)有限公司為受保人簽發「住院付款保證信」。請注意(1)本預先批核申請之結果並不構成或保證日後正式索償申請之批核及(2)日後索償申請之批核及可索償金額將由最終所提交之索償文件資料及保單條款決定。Please complete Part 1 on the following form by the Insured and Part 2 by the Attending Physician and send to MasterCare Customer Service by fax (852)2325 4833 or email to claimspa@chinalife.com.hk at least 7 working days prior to admission to hospital. For urgent enquiries/assistance, please call our Hotline at (852)3999 5501. Subject to the approval of this pre-approval application, the Company shall appoint Europ Assistance Hong Kong Limited to issue a "Letter of Guarantee" to the Insured. Please note that (1) the result of this pre-approval application does not constitute or guarantee an approval of the subsequent claims application and (2) approval of the subsequent claims application and the reimbursable amount shall be subject to the provision of claims documents and according to the policy provisions.
- 請以正楷填寫本申請表。任何資料如有更改，受保人/保單持有人/索償人必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Insured / Policyholder / Claimant in full signature.
- 本申請表中所用之「本公司」或「貴公司」之表述指中國人壽保險(海外)股份有限公司。The expressions "the Company" or "our Company" used in this form refers to China Life Insurance (Overseas) Company Limited.
- 如受保人為十八歲或以上，受保人及保單持有人必須親自填寫及簽署本申請表，如受保人為十八歲以下，本申請表應由保單持有人及受保人之合法監護人填寫及簽署。如受保人/保單持有人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供關係證明及醫生證明。If the insured is at or above age 18, the Insured and policyholder must complete and sign this form by his or her good self. If the insured is under age 18, this form should be completed and signed by policyholder and the insured's legal guardian. In the event that the Insured/ policyholder is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant relationship proof and physician's statement provided.
- 若受保人/保單持有人/索償人以圖章蓋印簽署，必須由一位見證人予以見證。見證人之個人資料只會用於處理本索償申請及核實和確認本申請表簽署人的身份之用。If the Insured/Policyholder/Claimant uses a signature stamp, it must be witnessed by a witness. The personal particulars of the witness will only be used for the purpose of processing this claim and verifying and confirming the identity of the signatory of this form.
- 受保人/保單持有人/索償人之簽署必須與本公司之紀錄相同。The signature of the Insured / Policyholder / Claimant must be the same as the Company's record.
- 如有任何查詢，請與 閣下的保險中介人聯絡或致電本公司客戶服務熱線(852) 3999 5519 查詢。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (852) 3999 5519 for details.
- 本公司有權隨時更新此申請表，並接受或拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.hk 瀏覽及下載最新版本。The Company has the right to update this form from time to time and to accept or to reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.hk to view and download the latest version of the form.
- 如中英文版本有任何抵觸或不符之處，概以中文本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, the Chinese version shall prevail.

保單編號 Policy No.										

第一部份 – 索償資料
PART I – PARTICULARS OF CLAIM

A. 一般資料 GENERAL INFORMATION

1 **聯絡電話** Contact phone no: _____

2 **電郵地址** Email Address _____

3 **職業及行業(必須填寫)**
Occupation/Business (Compulsory) _____

4 **閣下有否因同一事故曾/將會向其他保險公司索償？如是，請提供該保險公司名稱及保單號碼。** Did/Will you make a claim against any other insurance company for the same incident? If yes, please indicate the name of insurance company and policy no.. ☐ 是 Yes ☐ 否 No

保險公司名稱 Name of Insurance Company	保單號碼 Policy No.	保障類別及保障金額 Type & Amount of benefit

B. 因意外住院 FOR HOSPITALIZATION DUE TO ACCIDENT

1 **意外發生日期及時間**
Date and time of the accident

年 Year	月 Month	日 Day	時 Hour	分 Minute	AM/PM

2 **意外發生地點** Place of accident occurred **請描述症狀** Please describe symptoms

3 **意外發生之起因及受傷詳情** Please describe the reason of accident and details of injury

C. 因疾病住院 FOR HOSPITALIZATION DUE TO ILLNESS

1 **病症名稱** Name of illness

2 **請描述症狀** Please describe symptoms

3 **症狀何時開始出現?** When did these symptoms first appear? 年 Year _____ 月 Month _____ 日 Day _____

D. 治療詳情 TREATMENT DETAILS

1 **初診醫生/醫院的資料:** The physician/hospital first consulted for this injury or illness.

首次求診日期 Date of first consultation:
年 Year _____ 月 Month _____ 日 Day _____

醫生/醫院名稱及地址 Name & Address of Physician/Hospital

2 **其他曾診治此症或過往類似病況的醫生/醫院資料:** Other physicians/hospital consulted for this or similar conditions:

求診日期 Date of consultation:
年 Year _____ 月 Month _____ 日 Day _____

醫生/醫院名稱及地址 Name & Address of Physician/Hospital

保單編號 Policy No.										

E. 收取差額費用之信用卡授權書 (此部份必須填寫) CREDIT CARD AUTHORIZATION FORM FOR SHORTFALL COLLECTION (THIS SECTION IS MANDATORY)

如中國人壽保險(海外)股份有限公司(以下簡稱"本公司")直接向醫院支付的費用超出合資格索償的應支付賠償額，或有關差額或費用不屬於保障範圍，此授權書將授權本公司從以下信用卡戶口收取有關差額或費用。信用卡持卡人必須為相關保單之保單持有人或受保人。本公司將於發出「差額賠款通知書」的十四天後扣取有關差額及費用。如最終不能成功收取有關差額，我們將保留採取適當措施(包括但不限於展開法律程序)或於下次理賠金額中扣除上述款項的權利，同時拒絕 閣下日後之住院直付預批核申請。If the expenses which China Life Insurance (Overseas) Company Limited (hereinafter called "the Company") paid directly to the hospital exceeds the eligible amount of qualified claim or the relevant shortfall or expenses is not included in the benefit coverage, this authorization form will authorize the Company to debit the relevant shortfall or expenses from the credit card account below. The credit card holder must be the Policyholder or the Insured of the Policy. The Company will debit the outstanding shortfall or expenses from the credit card account below 14 days after the issuance of "Shortfall Payment Advice". If we could not successfully receive the shortfall payment, we will reserve the right to take appropriate actions (including but not limited to commencing legal proceedings) or deduct the above shortfall amount from future claims, and reject the hospitalization direct billing pre-approval application afterwards.

持卡人姓名： Cardholder's Name:		**持卡人身份證/護照號碼:** Cardholder I.D. Card/Passport No.:		**持卡人簽署:** Cardholder's Signature:	
信用卡戶口號碼: Credit Card Account No.:		**信用卡到期日:** Credit Card Expiry Date:			
信用卡類別*: Credit Card Type*:	☐ Visa ☐ Mastercard 萬事達卡	**持卡人聯絡電話:** Cardholder's Contact Phone No.:			
持卡人與病者關係: Relationship between cardholder and patient: **請在適當格內加上剔號** (Please tick the appropriate box)		☐ **保單持有人** Policyholder ☐ **病者本人** Patient		**年Year**	**月Month** / **日Day**

本人/我們，受保人/保單持有人/索償人，謹聲明上述提供之信用卡資料均為事實之全部並確實無訛，並同意授權及指示中國人壽保險(海外)股份有限公司從本人以上信用卡戶口扣除有關差額或費用(如適用)。I/We, the Insured/Policyholder/Claimant, hereby declare that above credit card information provided is complete and true, and agree to authorize and instruct China Life Insurance (Overseas) Company Limited to debit the outstanding shortfall or expenses (if applicable) from my above credit card account. *只接受由香港銀行發出的 Visa 及萬事達卡 Only accept Visa and Mastercard issued by banks in Hong Kong.

F. 個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

本人/我們確認已閱讀及明白「中國人壽保險(海外)股份有限公司」的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 https://www.chinalife.com.hk/zh-hk/privacy-policy 下載或向中國人壽保險(海外)股份有限公司索取。I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from https://www.chinalife.com.hk/zh-hk/privacy-policy or is made available upon request.

G. 聲明及授權 DECLARATION AND AUTHORIZATION

授權 Authorization

本人/我們，受保人/保單持有人/索償人，代表本人/我們及尚未成年之受保人(如有)謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、政府部門，或其他機構、組織或人士，凡知道或具有任何有關本人/我們/尚未成年之受保人之紀錄、認識或資料者，均可將該等資料提供、發放及轉交給中國人壽保險(海外)股份有限公司(以下簡稱「貴公司」)；(2) 貴公司或任何其指定之醫療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/尚未成年之受保人進行所需之醫療評估及測試，作為審核本人/我們/尚未成年之受保人之健康狀況。此授權對本人/我們之繼承人及授讓人具有約束力；即使本人/我們死亡或無行為能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。I/We, the Insured/Policyholder/Claimant, represent me/us/ the Insured under 18 years old (if any) HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, government department, or other organization, institution or person, that is aware of or has any records, knowledge or information of me/us/the insured under 18 years old to disclose, release and transfer such information to China Life Insurance (Overseas) Co. Ltd ("the Company"); (2) the Company or any of its appointed medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ ourselves/ the insured under 18 years old in relation to this claim. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

本人謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實之全部並確實無訛； 本人明白倘有任何未知是否屬於重要事項的資料均須透露；(2)本人對任何人所作出之任何聲明，如沒有在此申請表上填寫或印出，貴公司不須受其約束。若相關人士不能提供任何此申請表所需的資料，貴公司可能因此不能審核及處理此預先批核申請。I HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; I also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I may have made to any person if not written or printed here. If any relevant persons fail to provide any information requested in this application form, it may result in the Company's inability to process and deal with this pre-approval application

H. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受保人 Insured			**保單持有人 / 索償人*** Policyholder / Claimant*			**見證人** Witness		
簽署 Signature									
姓名 Name									
身份證/護照號碼 I.D. Card / Passport No.									
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
***索償人與受保人/保單持有人關係** *Relationship with Insured/Policyholder									

保單編號 Policy No.										

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 Particulars of Patient

1 **病人姓名** Name of Patient _____ **年齡及性別** Age and Sex _____

2 **身份證/ 護照號碼** I.D. Card / Passport No. _____

3 **病人首次求診日** Patient first Consultation Date 年 Year ____ 月 Month ____ 日 Day ____

4 **醫院名稱** Name of Hospital _____

5 **預計入院日期** Expected Date of Admission 年 Year ____ 月 Month ____ 日 Day ____

6 **病人家庭醫生姓名** Patient's Family Doctor Name _____

7 **預計留院日數** Estimated length of stay ____ **住院級別** Bed Class ☐ 私家 Private ☐ 半私家 Semi-Private ☐ 大房 Ward

B. 疾病/受傷詳情及有關資料 ILLNESS / INJURY DETAILS AND RELATED INFORMATION

1 **請詳細說明首次會診時之徵狀和病症** Please describe the symptoms and complaints at first consultation.

_____

_____

2 **發病日期** Onset date of the symptoms/conditions 年 Year ____ 月 Month ____ 日 Day ____

3 **診斷** Diagnosis _____ **國際疾病分類編碼** ICD 10 Code _____

_____ _____

_____ _____

4 **是次入院/治療是否醫療需要？** Is the hospitalization/treatment medically necessary? ☐ 是 Yes ☐ 否 No

如是，請詳述。If "Yes", please give details. _____

5 **根據你的評估及意見，病人就是次的病況，是否可以單從門診設施中接受適當的治療？** Given the condition of the patient, is it possible to provide this treatment on an outpatient basis?

☐ 是 Yes ☐ 否 No

如不可以，請提供原因: If "No", please explain: _____

6 **此病況是否為復發性/慢性?** Is the condition recurrent / chronic? ☐ 是 Yes ☐ 否 No

如"是"，請提供首次發病日期 If "Yes", please provide the onset date of the first episode:

年 Year ____ 月 Month ____ 日 Day ____

7 **如是次住院/治療由意外事故引起，請提供以下詳情：** If this hospitalization/treatment was caused by an accident, please provide details below:

事故發生日期 Accident Date: 年 Year ____ 月 Month ____ 日 Day ____

原因 Cause: _____

受傷位置及受傷程度 Part of body injured & extent of injury: _____

8 **病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址** Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. ☐ 是 Yes ☐ 否 No

轉介醫生姓名 Name of the referring doctor _____ 轉介醫生地址 Address of the referring doctor _____

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B. 疾病/受傷詳情及有關資料(續) ILLNESS / INJURY DETAILS AND RELATED INFORMATION(Continued)

9 **請選出與是項疾病有關之狀況。** Is the illness associated with the following?

- ☐ 先天性疾病 Congenital condition
- ☐ 自殘 Self-inflicted injury
- ☐ 不育或絕育 Infertility or sterilization
- ☐ 精神紊亂 Mental disorder
- ☐ 濫藥或酗酒 Abuse of drugs or alcohol
- ☐ 性病 Venereal disease
- ☐ 視力矯正 Corrective aids or treatment of refractive errors
- ☐ 康復/療養 Rehabilitation/ convalescence
- ☐ 整容或整形治療 Cosmetic or plastic surgery
- ☐ 發育異常 Develop-mental abnormality
- ☐ 參與危險性運動/活動 Hazardous sport / activity
- ☐ 遺傳性疾病 Hereditary condition
- ☐ 一般身體檢查/防疫注射 Body check vaccination & immunization injections
- ☐ 愛滋病或人體免疫缺損病毒感染 AIDS or HIV related illness
- ☐ 懷孕，請說明預產期 Pregnancy, please provide expected date of delivery
- ☐ 其他疾病，請說明 Other disease, please specify
- ☐ 以上皆否 None of the above

10 **請選出病人過往有否以下病症/習慣。** Does the patient have any medical history or habit as indicated below?

- ☐ 哮喘 Asthma
- ☐ 心臟病 Cardiac problem
- ☐ 糖尿病 Diabetes Mellitus
- ☐ 乙型肝炎 Hepatitis B
- ☐ 高血壓 Hypertension
- ☐ 曾接受手術 Previous operation
- ☐ 濫藥 Drug abuse
- ☐ 家族性癌症 Family history of cancer
- ☐ 家族病史 Unfavorable family history
- ☐ 以上皆沒有 None
- ☐ 其他疾病，請說明 Other disease, please specify

11 **該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療 ？ 如有，請說明詳情。** Had the patient previously been treated or hospitalized due to the above disease or other major disease? If so, please specify details.

☐ 有 Yes ☐ 沒有 No 診治日期 Date of diagnosis/treatments 年 Year 月 Month 日 Day

疾病 Disease

治療/住院詳情 Details of Treatment / Hospitalization

醫生姓名/醫院名稱 Name of Physician/Hospital

12 **請提供飲酒/吸煙習慣詳情** Please provide details of drinking & smoking habit

每日用量(支/包/樽/罐) Daily consumption (piece/ pack/ bottle/ can)

習慣始自 Drinking/ Smoking start date since 年 Year 月 Month 日 Day

C. 治療詳情及預計費用 TREATMENT DETAILS AND COST ESTIMATION

1 **治療計劃或手術名稱** Treatment plan or Surgical procedure name

麻醉 Anesthesia

☐ 全身麻醉 G.A. ☐ 局部麻醉 L.A. ☐ 監測麻醉 M.A.C

2 **建議之化驗 / 影像檢查 / 其他診斷性檢查及接受該等檢查的原因。** Please list out any Lab tests/Imaging/other diagnostic investigations required for this hospitalization and reasons for the same.

3 **是否可以單從門診設施中接受該等檢查？如否，請解釋原因** Can the investigations be carried out in the outpatient setting? If no, please explain why.

4 **是次提供的治療、治療程序、檢測是否為尚未能確定成效或屬實驗性質或仍在試驗階段的治療?** Has the treatment, procedure or test not yet been established as being effective or is experimental or is in trial stage? ☐ 是 Yes ☐ 否 No

如是，請詳述並提供原因 Please provide details:

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5 治療預計費用 Cost estimation of treatment:

住房及膳食費 Room and board	HK$		每日 Per Day
主診醫生巡房費 Attending physician's Visit Fee	HK$		每日 Per Day
外科醫生費(請列出明細；如有) Surgeon's Fee (with breakdown; if any)	HK$		
麻醉師費用(請列出明細；如有) Anaesthetist's Fee(with breakdown; if any)	HK$		
手術室費用 Operating Theatre Fee	HK$		
醫院雜項費用 Miscellaneous Expenses	HK$		
其他費用(例如專科醫生費及其他) Other Expenses (e.g. specialist fee etc.)	HK$		
入院前及出院後之門診護理 Pre and post hospitalization outpatient follow up	HK$		
預計總費用 Total estimate fee	HK$		

D. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

本人謹此聲明，就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。本人已向病人解釋上述預算費用，並徵得其同意。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief. I have explained to the patient the details of the above estimated charges and have sought his / her agreement.

主診醫生姓名 Name of Attending physician		資歷 Qualification			
地址 Address		聯絡電話 Contact No.			
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and Stamp of Hospital/ Clinic		日期 Date	年 Year	月 Month	日 Day