Blue Cross 藍十字
An AIA Company 友邦保險成員公司

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Personal Information Collection Statement

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OUTPATIENT CLAIM FORM 門診索償申請表

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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Claim Notes

1. This form is applicable to outpatient claim. **Each claim form is for one Insured (Patient) only**.
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. 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.

Claim Instructions

1. Attach the **original** receipts issued by the doctor 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 consultation/Date of treatment
   - Diagnosis
   - Breakdown of charges
   - Doctor's signature and official stamp
2. For outpatient visits in government hospital/clinic, please attach the original receipts together with a copy of medical certificate/sick leave certificate with specified diagnosis or 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. If laboratory tests/X-rays are necessary, please attach the doctor's referral letter unless it is waived.
4. For treatment of Chinese Medicine Practitioner, please attach the original receipts and prescription.
5. Complete and sign this form.
6. Provide copy of claim settlement advice from other insurers, if applicable.
7. Original receipt will not be returned once submitted. Please tick the appropriate box if certified true copy of receipt is required.

索償注意事項

1. 此申請表適用於門診索償。**每名受保人（病人）須獨立填寫申請表**。
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 查閱帳戶資料。
3. 請以 A4 紙打印此索償申請表，並於治療後 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。

索償申請指示

1. 附上由醫生簽發的收據**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**必須**列明以下資料：
   - 病人姓名
   - 診症日期 / 治療日期
   - 病症名稱
   - 收費項目說明
   - 醫生簽署及蓋章
2. 請附上由政府醫院或門診發出的收據正本及附有病症名稱的醫療證明書 / 病假證明書或出院撮要副本。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. 除已獲豁免外，如須接受化驗或 X 光診斷，請附上醫生轉介信。
4. 如屬中醫治療，請附上收據正本及中醫處方正本。
5. 填妥此申請表及簽署。
6. 如適用，請提供其他保險公司之賠償結算通知書副本。
7. 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。

To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 1/2 部分

（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。

Please fill in the nature of claim and breakdown of charges 請填寫索償性質及各項收費

No. 序號	Date of Consultation/ Treatment 診症 / 治療日期 (DD/MM/YY 日 / 月 / 年)	Nature of Claim (please put a "✓" in the appropriate box) 索償性質（請於適當方格內畫上「✓」號）							Total amount indicated on the receipts (please specify currency) 收據總金額 (請列明貨幣)
		General Practitioner's Consultation 普通科 醫生診症	Specialist's Consultation* 專科 醫生診症*	Chinese Medicine Practitioner Treatment# 中醫治療#	Prescribed Medicine and Drugs** 處方藥物**	Diagnostic X-rays and Lab Tests* X光診斷及 化驗*	Others (please specify, e.g. Physiotherapy*, Chiropractic*, Routine Check-up, etc.) 其他（請註明，如 物理治療*, 脊椎治療*，常規健康檢查等）	If Post-hospitalisation/Surgical follow up visit, please specify the date of Hospitalisation/Surgery 如住院 / 手術後的覆診，請註明 住院 / 手術日期 (DD/MM/YY 日/月/年)	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

*Doctor's referral letter is required unless it is waived 除已獲豁免外，必須連同醫生轉介信遞交

#Chinese Medicine prescription is required (if applicable) 必須連同中醫處方遞交（如適用）

**Doctor's prescription is required unless it is waived 除已獲豁免外，必須連同醫生處方遞交

To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 2/2 部分

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

If treatment is due to pregnancy, please give expected date of delivery. 若治療是因懷孕引致，請提供預產日期。Claims will be processed after the delivery of baby and the submission date of documentary proof will be extended to 60 days from the date of delivery (applicable to those members with Maternity Benefits) 索償申請會於分娩後處理，提交證明文件之期限將延長至由嬰兒出生日起計60天內（適用於附有產科保障的成員）。 _____ (DD/MM/YY 日 / 月 / 年)

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。