Bupa Clinical Claim Form 保柏門診賠償申請表

Sun Flower Insurance Brokers Limited

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

Must be completed 必須填寫

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.									
4.									
5.									

* Doctor's referral letter is required 必須連同醫生轉介信遞交　　# Chinese Medicine prescription is required 必須連同中藥藥方遞交

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 / the Member have / has been observed or treated or any insurance company or organisation that has any records or health information concerning me and / or the Member 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 fail to provide any information requested in this claim form, it may result in the inability of Bupa to accept or process this claims.
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 / 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。

Personal Information Collection Statement

Purposes: I understand and agree that all personal information relating to me / the Member collected or held by Bupa, whether contained in this application, or obtained in any claim processing procedure or otherwise from time to time, may be used by Bupa for the purposes of (1) processing this application and providing subsequent services; (2) processing any claims analysis and/or medical or other insurance-related checks; (3) provision and design of products and services of Bupa or any of its group companies; (4) marketing of products and services of Bupa or any of its group companies (but not other persons or organisations); (5) data matching, statistics and research; (6) communication with me / the Member in relation to any of the purposes set out in this statement; and (7) satisfying any applicable legal or regulatory requirements.

Classes of data transferees: I further agree that such personal information may be transferred for the purposes as specified above to any of the following parties (within or outside Hong Kong): any group company of Bupa, any insurance intermediary as authorised by myself, any reinsurance company, any claims investigation company, any service provider providing services to Bupa, any association or federation relating to the insurance industry or any person or organisation as required by law.

Consequences of non-provision of personal information: I understand that Bupa may be unable to process this application if I fail to provide any information requested in this application or otherwise by Bupa.

My rights in respect of my personal information: I further understand that (1) under the Personal Data (Privacy) Ordinance, I / the Member shall have the right to request access to and correction of any personal information concerning me / the Member provided to Bupa; and that all such requests can be made in writing and addressed to the Personal Data Privacy Officer of Bupa at 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong or by other means as Bupa may notify me from time to time; and (2) I / the Member can contact Bupa's Customer Care helpdesk on 2517 5333 (individual members) / 2517 5388 (group members)* for any enquiries about the Personal Information Collection Statement.

個人資料收集聲明

用途：本人明白及同意保柏透過此申請、任何索償程序或其他途徑不時收集或持有之所有有關本人/會員的個人資料，可供保柏作以下用途 (1) 處理此申請及提供售後服務；(2) 處理任何索償分析及/或與醫療或其他保險有關的查核；(3) 提供及設計保柏或其集團機構的產品及服務；(4) 推廣保柏或其集團機構的產品及服務 (但不會包括其他人士或機構)；(5) 資料核對、統計及研究；(6) 就任何本聲明中所述的用途與本人/會員聯絡；及(7) 遵守法律或監管要求。

資料承讓人的類別：本人亦同意該等個人資料可因上述用途提供予以下機構(在香港境內或境外)：任何保柏的集團機構、本人委任的保險中介人、再保險公司、賠償調查公司，為保柏提供服務的供應商機構，保險業協會或聯會、或法律要求的任何人士或團體。

未能提供個人資料的後果：本人明白若本人不能提供此申請或保柏要求的其他資料，保柏不能處理此申請。

有關個人資料的權利：本人明白(1) 根據個人資料(私隱)條例，本人/會員有權查閱及修正保柏所持有關於本人/會員的任何個人資料。有關要求請致函保柏個人資料私隱主任收，地址為香港鰂魚涌華蘭路25號大昌行商業中心18樓，或按保柏不時通知本人的其他途徑遞交；及(2) 本人/會員如對個人資料收集聲明有任何查詢，可致電保柏的客戶服務專線2517 5333 (個人計劃會員) / 2517 5388 (團體計劃會員)*。

Date 日期 _____

X _____
Signature of Member 會員簽署

Remarks: before sending in this form, please read below Claims Procedures 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下面之索償程序。

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

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

Please send this completed claim form with attachment(s) to ：填妥之賠償申請表及附帶文件請交回：

Bupa (Asia) Limited - Claims Dept.　保柏（亞洲）有限公司－理賠部收
18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong
香港鰂魚涌華蘭路 25 號大昌行商業中心 18 樓
Customer Care helpdesk 客戶服務專線：
- Individual members 個人計劃會員 (852) 2517 5333
- Group members 團體計劃會員 (852) 2517 5388
- Bupa Gold members 保柏尊貴寶會員 (852) 2517 5383

Facsimile 傳真：(852) 2548 1848
www.bupa.com.hk

Bupa 保柏

OP/BCFC-CC/0310-300K