5012000201

團體門診賠償申請表
Group Outpatient Claim Form

CSM-CLA20

保單號碼 Policy No.	投保公司 Name of Employer
賠案批號 Claim No.	收表日期 Date of Receipt

員工身份證號碼 Staff I.D. Card No.	員工姓名 Staff Name	診症日期 Consultation Date	普通科門診金額 General Consultation Fee	X光/化驗金額 Lab/X-ray Fee	中醫/ 跌打/ 針灸金額 Chinese herbalist/ bonesetter/ acupuncture Fee	牙科金額 Dentist Fee	病症 Diagnosis

* 閣下於填寫此索償申請表時，必須提供表格內要求之所有資料。
* Please provide all the information required in this form.
* 請檢查 閣下提供之中醫或西醫門診賬單/結單/收據正本內是否清楚註明病人姓名、診症日期、診斷病症、醫療費用及醫生簽署。
* Original receipt must include: Name of Patient/ Date of Consultation/ Diagnosis/ Amount of Charges and Doctor's Signature & stamp.
* 若申請專科、X 光化驗、物理治療及脊椎治療索償，請提供有關之醫生推薦書。
* The Attending Physician's referral for Specialist, Lab, Test, X-ray, Physiotherapy and Chiropractic (where appropriate) claims must be attached.
* 此表格必須由受保人在診症後九十天內填報及寄回本保險公司，逾期申請均不獲處理。
* This Claim Form must be completed and returned to the Insurance Company by the claimant within 90 days after incurring such expenses; otherwise claim will not be approved.

日期 Date

僱主簽署及公司印章
Authorized Signature of Employer and Co. Stamp