團體住院及手術賠償申請表 GROUP HOSPITALIZATION & SURGICAL CLAIM FORM

團體保單號碼 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'S STATEMENT To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 PARTICULARS OF PATIENT

病人姓名 Name of patient		病人年齡/性別 Age/sex of patient	/	病人身份證/護照號碼 I.D / Passport No. of patient	

B. 診治資料 CONSULTATION DETAILS

		年 Year	月 Month	日 Day
1	病人之醫療記錄可追溯至 We can trace the medical record of patient back to		/	/
2	首次出現病徵日期或意外發生日期 Date of the accident occurred or symptoms first appeared		/	/
3	病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness		/	/
4	病人最後月經日期(只適用於生育保障)Date of last menstruation (Only applicable for maternity benefit)		/	/
5	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			
6	如因意外住院，請提供意外詳情 For hospitalization due to accident, please provide accident details			

7 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

8	診斷 Diagnosis	國際疾病分類編碼 ICD 10 Code

C. 住院及手術資料 HOSPITALIZATION & SURGICAL DETAILS

1	醫院/診所名稱 Name of hospital/clinic		年 Year	月 Month	日 Day
		入院/門診手術日期 Date of admission/day surgery		/	/
		出院日期 Date of discharge		/	/
		入住及離開深切治療部 Period in Intensive Care Unit		/	/
				/	/

2	手術資料 Surgical Procedure Details	手術日期 Date of surgery		/	/

手術名稱 Name of the Surgical Procedure   醫療服務術語編碼 CPT Code

5012100301

C. 住院及手術資料 (續) HOSPITALIZATION & SURGICAL DETAILS (Continued)

3 住院/手術期間之治療、檢查及其結果、有否任何併發症及出院/手術後之覆診或跟進計劃 Treatments, investigation procedures, results, and/or any complications during hospitalization/surgery and post-hospitalization/post-surgery follow up plan..

4 病人在入院前/手術前連續三個月曾否就此疾病接受治療或求診？如有，請提供相關詳情。
Had the patient been treated or consulted for this condition in past 3 consecutive months prior to hospitalization/ undergone surgery? If yes, please provide details.

☐ 是 Yes　　☐ 否 No

醫生姓名 Name of the physician　　　　　醫院名稱 Name of hospital

治療日期 Treatment date　　　　　　　　治療詳情 Treatment details

5 病人有否於住院期間請假外出？如有，請列明外出及返回之日期及時間。 Has the Insured taken any home leave during the hospital confinement? If yes, please state the starting and ending date and time.

D. 閣下之專業意見 PROFESSIONAL COMMENT

1 是次檢查，治療及住院日數(如有) 是否與上述診斷有直接關係而且是醫療所需及由醫生建議?
Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were medically necessary and recommended by you? ☐ 是 Yes ☐ 否 No
如否，請詳述. **If No, please provide details** (如: 是否由病人要求住院? **E.g. Was the hospitalization requested by patient?**)

2 該檢查及手術可否在門診 / 日間手術中心進行? **Can the medical test(s) and the operation procedure be done on an outpatient basis / at day surgery centre?** ☐ 是 Yes ☐ 否 No
如否，請註明臨床風險、須留院的醫院原因及詳述現時健康狀況 (合併症): **If No, please indicate the clinical risk(s) , medical reason(s) for hospitalization and current Health Status (Co-morbidity) :**

3 手術是否必須在全身麻醉下進行? **The surgery could only be performed under general anesthesia?**
☐ 是 Yes ☐ 否 No
如手術在監察下麻醉進行，請註明住院原因 **For surgery under Monitored Anesthesia Care, please specify the reason for hospital stay.**

4 是次檢查，治療及住院是否緊急個案? **Is it a case of emergency?**
☐ 是 Yes ☐ 否 No
如是，請詳述並提供原因 **Please provide details:**

5 是次病症或受傷是否(1)復發個案，或(2)任何慢性疾病/ 嚴重疾病之併發症，或(3)與過往其他病況有關？如是，請提供有關診治日期及治療詳情。**Is the condition (1) a recurrent episode or (2) a complication of any chronic illness/ major disease or (3) related to any previous conditions? If yes, please provide date of diagnosis and treatments details.**
☐ 是 Yes ☐ 否 No　診治日期 Date of diagnosis/treatments　年 Year _____ 月 Month _____ 日 Day _____
詳情(包括診斷/治療/檢查及結果) Details (including diagnosis/ treatments/ investigations and results)

D. 閣下之專業意見(續) PROFESSIONAL COMMENT (Continued)

6 是項疾病之根本主因 What is the underlying cause of such illness?

7 病情預測及復發之可能 The prognosis of the condition and any possibility of having a relapse?

8 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

E. 其他醫療病史 OTHER MEDICAL HISTORY

1 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

2 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 _____

3 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 _____

F. 主診醫生資料 PARTICULARS OF ATTENDING PHYSICIAN

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。 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.

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 _____