中國人壽 CHINA LIFE | 海外

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

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 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 治療地點 Treatment Location

☐ 住院 Hospitalization 名稱 Name _____

地址 Address _____

☐ 診所/醫院日間醫療中心 Clinic/Hospital Day Centre 名稱 Name _____

地址 Address _____

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病徵和病症 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 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

5 麻醉 Anaesthesia

☐ 全身麻醉 G.A. ☐ 監察麻醉 M.A.C. ☐ 局部麻醉 L.A.

6 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. _____

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

7 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

8 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:

9 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

10 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

11 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

12 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

13 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 TREATMENT DETAILS

1 治療計劃 Treatment plan

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C. 治療詳情(續) TREATMENT DETAILS (Continued)

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 如屬住院治療，是否可以單從門診設施中接受該等檢查？如否，請解釋原因 **For hospitalization, can the investigations be carried out in the outpatient setting? If no, please explain.** ☐ 是 Yes ☐ 否 No

4 如屬門診/日間癌症治療，請提供以下資料 **For outpatient/day-patient cancer treatment, please provide the following**

☐ 放射治療 Radiotherapy 次數 Frequency	
☐ 化學治療：藥物名稱及次數 Chemotherapy: Drug name and frequency	
☐ 標靶治療：藥物名稱及次數 Targeted therapy: Drug name and frequency	
☐ 免疫治療：藥物名稱及次數 Immunotherapy: Drug name and frequency	
☐ 激素治療：藥物名稱及次數 Hormonal therapy: Drug name and frequency	

5 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:**

D. 治療預計費用 COST ESTIMATION OF TREATMENT

1 住院或門診/日間醫療預計費用 **Cost estimation of hospitalization or outpatient/day-patient**

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$		

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D. 治療預計費用（續） COST ESTIMATION OF TREATMENT (CONTINUED)

2 門診/日間癌症治療預計費用 Cost estimation of outpatient/day-patient cancer treatment

序號 No.	診症日期 Consultation Date			收費明細 Breakdwon of charges(HK$)		
	日 Day	月 Month	年 Year	診症費 Consultation Fee	癌症治療費 Cancer Treatment Fee	診斷檢測費 Diagnostic Test Fee
1						
2						
3						
4						
5						
總金額 Total						

E. 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