

直付預先批核申請表 (只適用於非尊尚醫療計劃)
DIRECT BILLING PRE-APPROVAL APPLICATION FORM
(APPLICABLE FOR NON MASTERCARE MEDICAL PLAN)

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.



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陷損病毒感 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

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:

6 如屬門診訂明診斷成像檢測*治療，請提供以下資料 For outpatient prescribed diagnostic imaging tests, please provide the following

- 電腦斷層掃描 Computed Tomography ("CT" scan)
- 磁力共振掃描 Magnetic Resonance Imaging ("MRI" scan)
- 正電子放射斷層掃描 Positron Emission Tomography ("PET" scan) including PET-CT combined and PET-MRI combined

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/日間癌症治療或門診訂明診斷成像檢測預計費用

Cost estimation of outpatient/day-patient cancer treatment or outpatient Prescribed Diagnostic Imaging Tests

序號 No.	診症日期 Consultation Date			收費明細 Breakdown of charges(HK\$)			
	日 Day	月 Month	年 Year	診症費 Consultation Fee	癌症治療費 Cancer Treatment Fee	一般診斷檢測費 Diagnostic Test Fee	訂明診斷成像檢測費用* Prescribed Diagnostic Imaging Tests*
1							
2							
3							
4							
5							

總金額 Total

*訂明診斷成像檢測只包括電腦斷層掃描 ("CT"掃描)、磁力共振掃描 ("MRI"掃描)、正電子放射斷層掃描 ("PET"掃描)、PET-CT 組合及 PET-MRI 組合。
* Prescribed Diagnostic Imaging Tests covered here only included computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

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