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團體醫療保險直付預先批核申請表
GROUP MEDICAL INSURANCE DIRECT BILLING PRE-APPROVAL APPLICATION FORM

團體保單號碼 Group Policy No.										

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由僱員/病者/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Employee's / Patient's / 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

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

☐ 住院 Hospitalization ☐ 醫院日間醫療中心 Hospital Day Centre ☐ 診所 Clinic

5 預計入院日期 Expected Date of Admission 年 Year ____ 月 Month ____ 日 Day ____

6 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徵狀和病症 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.

_____

7 如屬住院，病人就是次的病況是否可以單從門診設施中接受適當的治療？

For hospitalization, given the condition of the patient, is it possible to provide this treatment on an outpatient basis? 如不可以，請提供原因: If "No", please explain ☐ 是 Yes ☐ 否 No

_____

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

8 **此情況是否為復發性/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 ____

9 **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: _____

10 **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 _____

11 **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
☐ 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

12 **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 _____

13 **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 _____

14 **請提供飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit.**

習慣始自 Drinking/ Smoking start date since 年 Year ____ 月 Month ____ 日 Day ____

每日用量 Daily consumption _____ **(支/包/樽/罐 piece/ pack/ bottle/ can)**

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C. 治療詳情及預計費用 TREATMENT DETAILS AND COST ESTIMATION

1 治療計劃 Treatment plan

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 預計醫療費用 Estimation of Medical Expense

住房及膳食費 Room and board	HK$		每日 Per Day
醫生巡房費用 Doctor 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) Anesthetist'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$		

D. 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