Claim Procedure
보상 절차

Group Medical Insurance 단체 건강 보험
Claim Procedure 보상 절차

亞洲保險
ASIA INSURANCE

Hospitalization / Day Case Claim: 입원 또는 당일 수술 청구

- Please complete “Hospitalization & Surgical Claim Form” (Part I – complete by patient; Part II – complete by attending physician). 클레임 양식 작성 (Part I 환자 작성 / Part II 의사 작성)
- Please submit original receipts with completed claim form within 90 days after discharge of hospital. 퇴원 이후 90일 이내에 작성한 양식와 영수증 원본을 보상 부서로 송부
- For Hong Kong Government Ward hospital claim, the completion of Part II of the hospitalization claim form can be exempted if the Medical Practitioner’s diagnosis is stated on the receipt or payment slip or sick leave certificate or discharge summary.

  홍콩 정부병원 일반병실에 입원하는 경우, 영수증/청구서/병가증명서에 진단명이 기재되어 있으면 Part II 작성부분은 생략 가능

Group Medical Insurance 단체 건강 보험
Hospitalization & Surgical Claim Form 입원 클레임 양식

亞 洲 保 險
ASIA INSURANCE

索償表格
CLAIM FORM

Business Centre: 7/F & 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong T (852) 3606 9346 F (852) 2899 2426 E medical@afh.hk
Macau Branch: Avenida da Praia Grande, No.762, Edifício China Plaza, 10 andar C-D, Macau T (853) 2856 3166 F (853) 2857 0438 E asiamc@macau.ctm.net
asiainsurance.hk

醫療保險 — 住院及手術
MEDICAL INSURANCE CLAIM FORM - HOSPITALIZATION & SURGICAL PROCEDURE

Claims Document Checklist 索償文件參考表

Basic Requirements (must be completed)
- ☐ Part I completed by the patient with member cert number and signature
- ☐ Part II completed by the Attending Physician/ Surgeon with signature and chop
- ☐ Payment receipts with patient's name, treatment date, diagnosis and breakdown of charges:
  - First Claim: Original receipts
  - Second Claim: Certified true copy of receipts and claims statement advice by other insurer, if applicable

Additional Requirements (if applicable)
- ☐ Referral letter for Specialist consultation/ Private nursing/ Home nursing/ Home healthcare/ any kind of therapy treatment
- ☐ Copies of histopathology, endoscopic, diagnostic, laboratory tests reports, and surgical summary

No reimbursement or claims shall be made for:
- Claim(s) submitted after 90 days from the date of discharge/treatment
- Insufficiency of required information

基本要求 (必須填妥)
額外要求 (如適用)
根據以下情形，賠償申請將不獲辦理:

甲部 - 由病人填寫
PART I - TO BE COMPLETED BY THE PATIENT

本表格適用於住院或日間手術賠償
This form is applicable to both inpatient and day case procedure claim

保單持有人 / 僱主名稱 Name of Policyholder/ Employer			
僱員 / 受保人姓名 (只限團體保單) Name of Employee/ Insured Member (For group insurance policy only)		保單編號 Policy No.	
保戶號碼/職員號碼 (如適用) Certificate No./ Staff No. (if applicable)		日間聯絡電話 Daytime Contact Tel No.	
病人姓名 Name of Patient		身份証號碼 I.D. Card No.	
職業 Occupation		出生日期 Date of Birth	性別 Sex ☐男 M ☐女 F
與保單持有人關係 Relation with the Policyholder	☐本人 Self ☐僱員 / 成員 Employee	☐配偶 Spouse ☐僱員家屬 Dependent of Employee	☐子女 Child

(1) 閣下是否曾因同一病況而接受治療?
Have you ever received any prior treatment for this or related conditions? ☐沒有 NO ☐有 YES

醫生姓名 Doctor's Name ______
地址 Address ______
日期 Date(s) ______

(2) 有關此次住院 / 手術，閣下有否申請其他保險賠償 ?
Are you making any other insurance claim as a result of this hospitalization/surgery ? ☐沒有 NO ☐有 YES

保險公司名稱 Name of Insurance Company ______ 保單號碼 Policy No. ______

☐ 請退回單據以便申請其他保險賠償
Please return receipts for other insurance claims.

(3) 此次住院 / 手術是否由於一宗意外引致 ?
Was the hospitalization/surgery resulting form/related to any accident? ☐不是 NO ☐是 YES

日期 Date ______ 時間 Time ______ 地點 Place ______
經過 Brief Description ______

重要事項 IMPORTANT NOTES

Any personal information collected by the Company may be used, stored or disclosed to any individual or organisation to evaluate this application, to provide our services and products to you, including administering, maintaining, managing and operating such services and products, or to provide subsequent services. Requests for personal data access or correction may be addressed to Data Protection Officer of the Company.

It is our policy to comply with the requirement of the Personal Data (Privacy) Ordinance (Cap. 486) of the laws of the Hong Kong Special Administrative Region. Details of the Personal Information Collection Statement ("PICS"), please kindly refer to our website www.asiainsurance.hk. For any questions, requests for such access or correction can be made in writing to the Personal Data Protection Officer, Asia Insurance Company Limited, 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong SAR.

聲明及授權書 DECLARATION & AUTHORIZATION

I hereby authorise any hospital, physician, insurance company or organisation that has any records or knowledge of me or my health, to furnish to Asia Insurance Company Limited or its authorised representative, any and all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records for application and underwriting purpose. A photostat copy of this authorisation shall be considered as effective and valid as the original.

X ______ Signature of Patient/Parent or Legal Guardian (Applicable for age below 18)
X ______ 日期 Date

乙部 — 由主診/外科醫生填寫，所需費用由索償人自行承擔
PART II – To Be Completed by Attending Physician / Surgeon at the Claimant's Own Expenses

Name of Patient (in full) 病人姓名(全名): ______

Date of Admission 入院日期(DD日/MM月/YY年) ______ Date of Discharge 出院日期(DD日/MM月/YY年) ______

Name of Hospital 醫院名稱: ______

Level of hospital ward 病房級別: ☐ Private 頭等房 ☐ Semi-private 二等房 ☐ Ward 三等房 ☐ Clinical Surgery 門診小手術

1. Clinical History 求診記錄:

a) Are you the patient's usual physician? 閣下是否病人的慣常醫生?
- a) i. Yes 是 ☐ please fill in question b 請填寫問題 b
- ii. No 不是 ☐ Does the patient have any other usual / family doctor(s)? if Yes, please give us the name(s) and telephone no. 病人是否有其他的長期 / 家庭醫生? 如是者，請提供姓名及電話號碼 ______
- b) Please provide all the consultation date(s) and the brief summary of the related disorder/illness. 請填寫診治日期及與是次病症相關之摘要。______

If you are referred by other doctor, please provide the doctor name, contact number and address. 如閣下乃其他醫生轉介，請提供該醫生的姓名、聯絡電話及地址。______

b) Date of the first consultation with the patient for this illness/ injury 病人就此疾病/受傷後，首次向閣下求診的日期(DD日/MM月/YY年) ______

c) Symptom(s) / complaint(s) of the patient relating to this hospitalization / treatment / investigation 病人就此次住院 / 治療 / 檢驗所出現的相關症狀及主訴 ______

d) How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症狀多久? ______

2. Hospitalization Details 住院詳情:

a) Final Diagnosis 最後的診斷 ______ Date of Operation 手術日期(DD日/MM月/YY年) ______

b) Name of the operation performed 手術的名稱 ______

c) Please give a brief discharge summary (including onset and duration of signs and symptoms / disease, etiology, types and results of major examinations, treatments, complications and follow up plan) 請提供出院撮要(包括開始時及持續出現的徵兆 / 症狀、病因、主要檢查的種類及結果、治療、併發症及覆診詳情) ______

d) Please provide reason(s) for hospitalization if this type of cases can be managed on day care / out-patient basis.
若此次病症能在日間護理 / 診所內進行治療，請提供住院原因。______

e) Had the patient been previously treated or hospitalized for the same or in related disability? If so, please give a brief summary of the following:
病人過去曾否就相同或相關病症而需接受診治或入院接受治療? 如是，請說明撮要。

Dates 日期	Disease / Disorder / Complaint 疾病 / 失調 / 申訴	Type of treatment / hospitalisation 治療 / 住院的詳情	Name of doctor / hospital 西醫姓名 / 醫院名稱

f) If the patient has consulted other physician(s) during this hospitalization period, please provide the following:
如於住院期間曾向其他醫生求診，請提供以下資料:

Name of the physician(s) consulted 醫生姓名 ______ Reason 原因 ______
What kind of treatment did the physician provide to the patient? 醫生提供給病人之治療詳情? ______

g) Was the patient hospitalized as a result of recurrent episode or chronic illness or related to a previous complaint/ diagnosis.
If "yes", please provide date of first episode and details.
病人是次住院治療是否因緩發或慢性病病所引致或與以往的主訴/診斷有關?若答案為 "是"，請提供首次發病日期及詳情。______

h) Was the Medical condition due to or associated with the following? (Please tick the appropriate boxes)
上述情況是否出於或與以下問題關連(請在適當空格填上☑號)

- ☐ Accidental bodily injury 意外身體受傷
- ☐ Self-inflicted injury 自我傷害
- ☐ Abuse of drugs or alcohol 濫用藥物或酒精
- ☐ Mental disorder 精神紊亂
- ☐ Refractive error 屈光不正
- ☐ Venereal disease, sexually transmitted disease or AIDS / HIV related illness 性病，性傳播疾病或愛滋病 / 愛滋病毒有關的疾病
- ☐ Pregnancy 懷孕
- ☐ Infertility or sterilization 不育或絕育
- ☐ Contraception 避孕
- ☐ Treatment for cosmetic purpose 美容性質的治療
- ☐ Vaccination 疫苗接種
- ☐ Congenital condition 先天性疾病/異常
- ☐ Developmental condition 發育問題
- ☐ Hereditary condition 遺傳性問題
- ☐ General check-up 一般身體檢查

______ Signature and chop of attending physician / Surgeon 主診醫生 / 外科醫生簽名及蓋章
______ Address and Telephone No. 地址及電話號碼
______ Name of attending physician / Surgeon & qualifications 主診醫生姓名 / 外科醫生姓名及資歷
______ Date 日期(DD日/MM月/YY年)

Part II of this claim form is endorsed by the Hong Kong Medical Association and Medical Insurance Association of The Hong Kong Federation of Insurers.
本索償表格乙部已獲香港醫學會及香港保險業聯會屬下醫療保險協會認可。

Group Medical Insurance 단체 건강 보험
Claim Procedure 보상 절차

亞洲保險
ASIA INSURANCE

Outpatient Claim: 외래 진료 청구

1. Please complete “Outpatient Claim Form”. 외래 청구 양식 작성
2. Please submit original receipts with completed claim form within 90 days after consultation date.
   진료 이후 90일 이내에 클레임 양식과 영수증 원본 제출
3. The receipt should show the following information: 영수증에는 다음 정보가 포함되어야 합니다
   - ① Name of patient 환자 성명
   - ② Date of treatment 치료 일자
   - ③ Diagnosis 병명
   - ④ Doctor’s signature & chop 의사 서명 및 날인
   - ⑤ Charges 금액

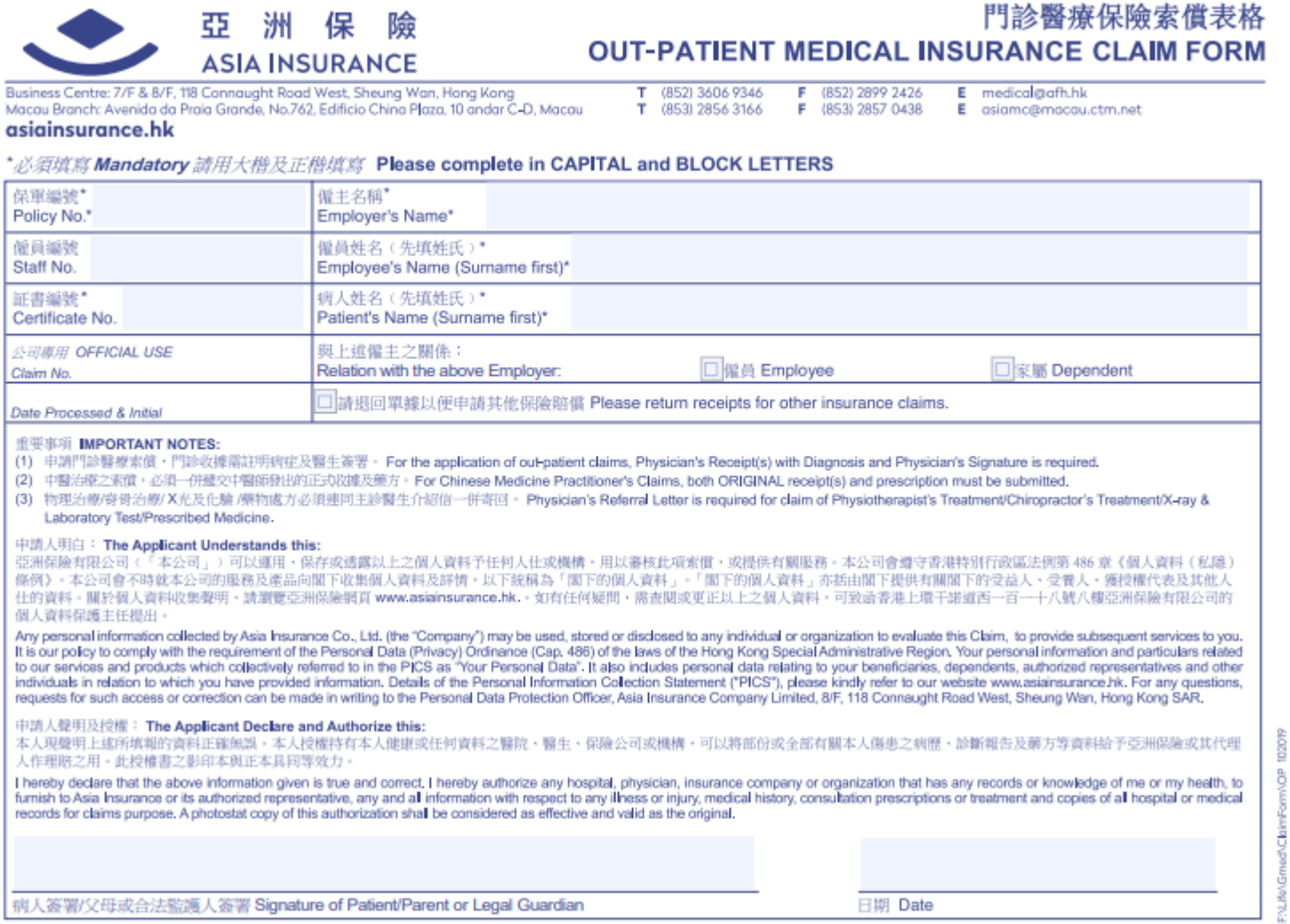
Referral letter is required for Physiotherapy, Chiropractor and X-Ray & Lab Test.
물리치료, 지압사, x레이 및 검사비용에 대해서는 진료의뢰서 필요

Validity of referral letter is 6 months from last consultation date.
진료의뢰서는 진료 이후 6개월간 유효

Medicine prescription is required for Chinese Herbalist claims.
한약 보상 청구를 위해서는 처방전 필요

Group Medical Insurance 단체 건강 보험
Outpatient Claim Form 외래 진료 클레임 양식

亞洲保險
ASIA INSURANCE



亞 洲 保 險
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門診醫療保險索償表格
OUT-PATIENT MEDICAL INSURANCE CLAIM FORM

Business Centre: 7/F & 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong T (852) 3606 9346 F (852) 2899 2426 E medical@afh.hk
Macau Branch: Avenida da Praia Grande, No.762, Edificio China Plaza, 10 andar C-D, Macau T (853) 2856 3166 F (853) 2857 0438 E asiamc@macau.ctm.net
asiainsurance.hk

*必須填寫 Mandatory 請用大楷及正楷填寫 Please complete in CAPITAL and BLOCK LETTERS

保單編號* Policy No.*	僱主名稱* Employer's Name*
僱員編號 Staff No.	僱員姓名（先填姓氏）* Employee's Name (Surname first)*
証書編號* Certificate No.	病人姓名（先填姓氏）* Patient's Name (Surname first)*
公司專用 OFFICIAL USE Claim No.	與上述僱主之關係： Relation with the above Employer: ☐ 僱員 Employee ☐ 家屬 Dependent
Date Processed & Initial	☐ 請退回單據以便申請其他保險賠償 Please return receipts for other insurance claims.

重要事項 **IMPORTANT NOTES:**
(1) 申請門診醫療索償，門診收據需註明病症及醫生簽署。 For the application of out-patient claims, Physician's Receipt(s) with Diagnosis and Physician's Signature is required.
(2) 中醫治療之索償，必須一併遞交中醫師發出的正式收據及藥方。 For Chinese Medicine Practitioner's Claims, both ORIGINAL receipt(s) and prescription must be submitted.
(3) 物理治療/脊骨治療/X光及化驗 /藥物處方必須連同主診醫生介紹信一併寄回。 Physician's Referral Letter is required for claim of Physiotherapist's Treatment/Chiropractor's Treatment/X-ray & Laboratory Test/Prescribed Medicine.

申請人明白： **The Applicant Understands this:**
亞洲保險有限公司（「本公司」）可以運用、保存或透露以上之個人資料予任何人仕或機構，用以審核此項索償，或提供有關服務。本公司會遵守香港特別行政區法例第 486 章《個人資料（私隱）條例》。本公司會不時就本公司的服務及產品向閣下收集個人資料及詳情，以下統稱為「閣下的個人資料」。「閣下的個人資料」亦指由閣下提供有關閣下的受益人、受養人、獲授權代表及其他人仕的資料。關於個人資料收集聲明，請瀏覽亞洲保險網頁 www.asiainsurance.hk。如有任何疑問，需查閱或更正以上之個人資料，可致函香港上環干諾道西一百一十八號八樓亞洲保險有限公司的個人資料保護主任提出。

Any personal information collected by Asia Insurance Co., Ltd. (the "Company") may be used, stored or disclosed to any individual or organization to evaluate this Claim, to provide subsequent services to you. It is our policy to comply with the requirement of the Personal Data (Privacy) Ordinance (Cap. 486) of the laws of the Hong Kong Special Administrative Region. Your personal information and particulars related to our services and products which collectively referred to in the PICS as "Your Personal Data". It also includes personal data relating to your beneficiaries, dependents, authorized representatives and other individuals in relation to which you have provided information. Details of the Personal Information Collection Statement ("PICS"), please kindly refer to our website www.asiainsurance.hk. For any questions, requests for such access or correction can be made in writing to the Personal Data Protection Officer, Asia Insurance Company Limited, 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong SAR.

申請人聲明及授權： **The Applicant Declare and Authorize this:**
本人現聲明上述所填報的資料正確無誤。本人授權持有本人健康或任何資料之醫院、醫生、保險公司或機構，可以將部份或全部有關本人傷患之病歷、診斷報告及藥方等資料給予亞洲保險或其代理人作理賠之用。此授權書之影印本與正本具同等效力。

I hereby declare that the above information given is true and correct. I hereby authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to Asia Insurance or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records for claims purpose. A photostat copy of this authorization shall be considered as effective and valid as the original.

病人簽署/父母或合法監護人簽署 Signature of Patient/Parent or Legal Guardian　　日期 Date

F:\Life\Gmed\ClaimForm\OP 102019

Group Medical Insurance 단체 의료 보험
Claim Procedure 보상 절차

1. 작성된 클레임 양식, 원본 의료 영수증, 진료의뢰서(해당되는 경우)를 아래 주소로 송부 :

   Submit completed claim form and all medical receipts with copy of referral letter, if applicable, to below address by **postal delivery**:

   Business Centre: 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong

   Attn: Employee Benefits (Group Medical Claims)

2. 공립 병원 관련 청구 비용이 HKD 30,000 미만인 경우 이메일 청구 가능 :

   Outpatient claims or Hospitalization claims at Public Hospitals with claim amount less than HK$30,000 can be submitted by :

   A. **Submit by iAsia platform** 온라인 플랫폼 제출 또는

   B. 이메일 제출 **Email to** ebclaims@afh.hk

      Please indicate policy number, patient name and cert number. 이메일에 영문성명, 보험 증권번호, 회원번호 기재

      Attach image of all Medical Receipt(s), Referral Letter (if applicable) and completed Claim Form (Outpatient / Hospitalization). 작성된 청구양식과 영수증, 진료의뢰서 이미지를 첨부

- Reimbursement will be made within 14 working days upon receipt of completed claim documents. 근무일 기준 14일 이내 보상。
- Payment Advice will be sent to employees. 직원에게 지급 통지 。

Group Medical Insurance 단체 건강 보험
Claims Hotline 보상 부서 핫라인

亞洲保險
ASIA INSURANCE

Hotline for Policy admin. : 3606 9308

Hotline for Claims : 3606 9346

Hotline for "iAsia" platform : 3606 9309

ebclaims@afh.hk

Monday – Friday

(except Public holidays)

9:00 a.m. to 6:00 p.m.

* If the hotline is busy, please leave your voice message incl. Your Name, Phone No., Email Address, Policy no., etc to follow up.

* 통화 중인 경우 보이스 메시지를 남겨주시면 고객 담당자가 후속 조치를 취합니다