太平洋保险 CPIC

太平洋健康保险股份有限公司
Pacific Health Insurance Co.,Ltd.

预授权申请表
Pre-Authorization Request Form

第一部分 被保险人信息 * 为必填项 **Part I Patient information *Mandatory**	
*姓名 Patient name:	*出生日期（年 / 月 / 日）Date of birth(YY/MM/DD):
*性别 Gender:	*联系电话 Telephone:
*证件类型 ID type:	*证件号码 Valid ID number:
*证件有效期 ： 年 月 日 至 年 月 日 ID validity period : From YY MM DD to YY MM DD	*邮件地址 E-mail:
*保单号 Policy number:	*单位名称 Company name:

第二部分 医疗机构信息 – 此处由诊疗医师填写 * 为必填项 **Part II Provider Information – to be completed by attending physician *Mandatory**	
*医疗机构 Medical facility:	*传真号码 Fax number:
*联系人 Contact person:	*联系电话 Telephone/Contact number:
*主治 / 主刀医生姓名 Attending doctor:	*邮件地址 E-mail:

第三部分 医疗信息 – 此处由诊疗医师填写 * 为必填项 **Part III Medical information – to be completed by attending physician * Mandatory**	
*需要治疗的疾病 (ICD 10) Condition/Diagnosis(ICD 10) requiring treatment:	*意外 / 病症出现日期（年 / 月 / 日） Accident/Symptoms occurring from （YY/MM/DD）:
	*根本病因 Underlying Cause:
*如果是慢性疾病、慢性疾病急性发作或是急性病情、意外等请如实告知 Please indicate if there have been chronic diseases, acute attack or symptoms of chronic diseases, acute symptoms or accidents, etc.: □慢性疾病 Chronic disease □慢性疾病急性发作 Acute attack of chronic disease □急性疾病 Acute disease □意外 Accident □其他 Others	*既往是否有这种症状或出现过相似的症状 Has this or any similar condition existing previously? □否 No □是 Yes (如果是，请提供相应医疗信息 If Yes, please attach details)
	*本次就诊日期（年 / 月 / 日） Date of this visit (YY/MM/DD):
*主诉 Chief complaint:	
*体格检查结果 Physical examination results:	
*实验室检查结果 Laboratory test results:	
*既往疾病及治疗史 Pre-existing conditions and medical history:	
*治疗方案 / 计划 Treatment plan/ procedure:	
*目前的药物治疗 Medication currently taken:	

第四部分（预估费用 - 请医疗机构相关部门填写）* 为必填项
Part IV Expenses estimated-To be completed by relevant medical facility *Mandatory

*拟诊疗形式 Admited as： □门诊 Outpatient □住院Inpatient

*住院日期 Admission date：

*住院天数 Estimated length of hospital stay：

*门诊手术费 Outpatient surgeon fee：

*麻醉费 Anesthetists' fee：

*手术及相关费用 Surgeon's fee & relevant cost：

*其他费用 Others：

*药费及敷料费 Prescribed drugs and dressing fee：

*床位费和膳食费（每日）Hospital accommodation(per day)：

*检查费 Examination fee：

*房间类别 Ward type：

*总费用约计 Hospital charges (Approx) ：

1．预授权是保险人审查医疗项目合理性和必要性的重要方式，目的是使被保险人获得更有效的医疗服务和理赔服务。无论保险人是否同意被保险人的预授权申请，均不构成保险人对于该预授权事项承担保险责任的承诺。在保险事故属于保险责任的情况下，如果存在被保险人未及时申请预授权或者申请后未获得保险人同意的情形，按照保险合同的规定，被保险人将承担一定的自负额。

Pre-authorization is an important way for the insurer to review the rationality and necessity of the medical treatment, whose purpose is to enable you to obtain more effective medical services and claims services. Regardless of whether we agree with your pre-authorization request or not, it will not constitute the guarantee for claim payment. When the event is within the policy liability and if you have not applied for the pre-authorization or obtained the approval of pre-authorization, you will bear the co-payment accordingly pursuant to the terms and conditions of insurance contract.

2．保险人仅对预授权申请表上的医疗信息进行审核，对于治疗期间涉及的其他需事先取得预授权的项目或变更诊断及治疗或需要延期住院的情形，被保险人必须重新申请预授权。

Please note that the insurer will only assess medical information stated in the pre-authorization request form. If there are any changes to the insured's diagnosis or proposed treatment, or if there are any complications that would require a change in treatment or extended hospital stay, you need to resubmit the pre-authorization form to us for future assessment.

3．请被保险人将预授权申请表及所有的检查报告和实验室结果复印件资料发送邮件至：Vipclaim@cpic.com.cn 或传真 +86（21）5596 1781, 如果没有填写预授权申请表或者重要信息缺失，可能给被保险人造成不必要的损失。

Please submit full medical reports and any laboratory test results along with completed pre-authorization request form to Email：vipclaim@cpic.com.cn; or Fax: +86（21）5596 1781. Failure to complete and submit this form or lacking important information could result in substantial loss for this patient.

4．本人授权任何医疗机构、社保或农保机构、保险公司、公安机关、疾病防治中心等有关机构以及一切熟悉被保险人身体健康状况、相关事故的人士，均可将有关被保险人资料向中国太保(指中国太平洋保险（集团）股份有限公司及其直接或间接控股的子公司)或通过中国保险行业协会、中国保险信息技术管理有限责任公司、保险交易所及其合作伙伴等中国太保所委托的合作机构如实提供。本人愿意承担由此产生的一切法律后果。

I authorize all relevant institutions including medical establishments, social insurance or rural cooperative agencies, insurance companies, public security organs and centers for disease control and prevention and all persons familiar with the physical health situation of the insured and relevant incident to provide relevant information and materials of the insured truthfully to CPIC, which refers to China Pacific Insurance (Group) Co., Ltd and it direct and indirect subsidiaries, through cooperative institutions entrusted by your company including the Insurance Association of China, China Insurance Information Technology Management Co., Ltd.(CIITC), insurance exchange and their cooperative partners. I am willing to undertake all the legal consequences arising therefrom.

5．中文内容具有法律效力，英文翻译仅供参考。

Chinese text has legal effect and English translation is for reference only.

*主治 / 主刀医生签名 Medical practitioner/surgeon signature: *日期Date:	*被保险人 / 监护人签名 Insured/ Guardian signature: *日期Date: