太平洋保险 CPIC

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

牙科治疗直付理赔申请书

Direct Billing Dental Claim Form

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.

注：若本次理赔金额小于10000元，带“▲”部分可不填写。

Note: If the claimed amount is less than RMB 10,000, columns with “▲” are optional.

被保险人基本信息

Basic Information of the Insured

姓 名 Name		性别 Gender		▲国籍 Nationality		▲职业 Occupation	
证件类型: □ 身份证 □ 护照 □ 其他 ID type: ID card Passport Others		证件号码 ID No.					
▲证件有效期 ID validity period	年 月 日 至 年 月 日 From YY MM DD to YY MM DD						
保单号码 Policy No.				预授权号 Pre-authorization No.			
联系电话 Tel		邮箱 E-Mail				邮编 Zip code	
联系地址 Contact address							

授权与声明

Authorization and Statement

1、本人声明以下陈述与回答全部属实，如有虚假，本人愿意承担法律责任。

I declare that the statements and answers below are true to the facts, and I am willing to undertake the legal liability for any false statement.

2、本人授权太平洋健康保险股份有限公司将本次申请应付保险金直接与医院进行结算；本人理解若此次理赔被发现有全部或部分欺诈，本人将承担相关法律责任。

I authorize Pacific Health Insurance Co.,Ltd. to directly settle due benefits with the medical provider. I understand that I shall undertake relevant legal liability if the claim is found to be complete fraud or partial fraud.

3、本人了解如所接受之医疗超出保险合同所约定的保障额度或保障责任范围，本人必须自行承担超出部分的相关费用并按太平洋健康保险股份有限公司的相关要求及时返还。若未及时返还的，本人接受太平洋健康险保险股份有限公司停止相关应付保险金直接与医院进行结算之服务。

I understand that for treatment I receive exceeding the agreed benefits or liabilities in the insurance contract, I should undertake the exceeded expenses by myself and timely return relevant expenses in accordance with the requirements of Pacific Health Insurance Co.,Ltd. In case of overdue repayment, I agree that Pacific Health Insurance Co., Ltd terminate the direct billing service of benefits payable with hospitals.

4、本人授权被保险人接受过治疗或住院或具有被保险人健康情况记录的任何内外科医生、医院 、诊所、公安、保险公司或任何组织，均可以将该事故、意外或疾病之细节、被保险人的健康情况、过往的病历、医嘱，以及任何住院、治疗、病历的详细资料提供给贵公司及贵公司所委托的合作机构。本人愿意承担由此产生的一切法律后果。此授权书的复印件与正本具有同样效力。

I authorize all physicians and surgeons who have health situation records of the insured and relevant institutions including hospitals, clinics, insurance companies, and public security organs where the insured is treated or receives inpatient treatment and have health situation records of the insured to provide details of the event, the accident, and the illness, health situation and medical records of the insured, medical advice for the insured, and any details of hospitalization, treatment and medical records for your company or entrusted cooperative institutions of your company. I shall undertake any legal consequences arising from this authorization. The copy of this authorization have the same effect as the original.

5、本人同意贵司向中国保险信息技术管理有限责任公司报送本人的全部保单信息和理赔信息，并通过医疗机构、中国保险信息技术管理有限责任公司及知悉本人信息的其他机构查询与本人有关的承保、理赔、医疗等信息。

I agree that your company shall report all of my insurance policy and claim information to CIITC, and inquire about underwriting, claim and medical information relating to myself through medical establishments, CIITC and other institutions aware of my personal information.

6、本人同意中国太保、中国保险信息技术管理有限责任公司收集处理被保险人姓名、性别、证件类型、证件号码、联系电话、地址、国籍/职业/证件有效期、医疗信息，用于准确识别本人投保信息和申请理赔的需要，但均应严格履行保密义务。

I agree that CPIC and CIITC can collect and process the information of the name, gender, ID type, ID No., contact telephone No., address, nationality/occupation/ID validity period and medical information of insured for the purpose of identifying correctly the insurance application information of myself and filing for claim, but such information must be kept in strict confidence.

申请人(本人/监护人)正楷签名： **申请日期：**

Signature of the claimant (Insured/ Guardian): **Date of application:**

医疗信息-此处由诊疗医师填写
Medical information – to be completed by qualified dental practitioner

出险类型Type of incident： □意外Accident □疾病Disease □其他Others		初诊日期（年/月/日）： Date of first treatment (YY/MM/DD)
初次就诊医院 Hospital for the first visit		本次病症初次发生日期（年/月/日）： Date of symptoms occurring for the first time (YY/MM/DD):
请提供该患者此次就诊的主要病情 Please describe the details of the event:		

请使用以下缩写填写牙科图表
Please fill in the dental chart with the abbreviations below:

	牙科图表Dental Chart															
	右Right								左Left							
治疗Treatment																
发现Finding																
上颌Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
下颌Lower Jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
发现Finding																
治疗Treatment																

Finding 发现				**Treatment 治疗**			
b	bridge 牙桥	gs	gingival swelling 牙龈肿胀	AF	amalgam 汞合金填充	O	orthodontics 齿列矫正
c	crown 牙冠修复	i	implant 植牙	CF	composite 复合材料填充	ON	onlay 高嵌体
ca	caries 龋齿	in	inlay 嵌体	D	denture 假牙	OR	oral radiograph 口腔 X 光片
da	decay 蛀牙	m	missing tooth 牙齿缺失	E	extraction 拔牙	PR	panoramic radiograph 全景 X 光片
dn	dental necrosis 牙齿坏	p	periodontis 牙髓炎	I	implant 植牙	RB	replacement bridge 牙桥更换
cl	calculus 牙石	pu/od	pulpitis or odontitis 齿髓炎	IN	inlay 嵌体	M	metal ceramic crown 金属烤瓷冠
g	gap closure 间隙封闭			RC	replacement crown 牙冠置换	NB	new bridge 新牙桥
gb	gingival bleeding 牙龈出血			RCT	root canal treatment 根管治疗	NC	new crown 新牙冠
gi	gingivitis 牙龈炎			S&P	scale and polish 去垢和抛光		

如果患者接受了 NC 或 RC 治疗，是否使用了贵金属或半贵金属? □是 Yes □否 No

If the treatment was NC or RC, was precious or semi-precious metal used

如果是，使用了哪种贵金属或半贵金属?

If yes, what precious or semi-precious metal has been used?

如果患者接受了 IN 或 ON 治疗，是否使用了贵金属或半贵金属？ □是 Yes □否 No

If the treatment was IN or ON, was precious metal or semi-precious metal used?

如果是，使用了哪种贵金属或半贵金属？

If yes, what kind of precious metal or semi-precious metal has been used?

声明：本人声明在此理赔申请表上的陈述内容是完整、真实和无保留的。

Declaration: I declare that to the best of my knowledge and beliefs, the statements made on this form are full, true and complete.

诊疗医师签字： 日期（年/月/日）：

Dental practitioner's signature: Date (YY/MM/DD)