太平洋保险 CPIC

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

医疗直付理赔申请书
Direct Billing Medical 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：带“▲”部分必填写。

Note: Fields marked with ▲ are mandatory.

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 ID type	□身份证 □护照 □其他 ID card Passport Others ________	▲证件号码 ID No.					
▲证件有效期 ID validity period	From	年 YY 月 MM	日 DD 至 to	年 YY 月 MM	日 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、本人同意中国太保及其合作的第三方理赔服务商、中国保险信息技术管理有限责任公司收集、存储、相互传输、委托处理本次理赔提交的被保险人的理赔信息与理赔资料，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, its third-party claims service providers, and CIITC collect, store, mutually transfer, and process the claim information and materials submitted in relation to this claim concerning the insured, for the purposes of verifying my insurance coverage and processing this claim. All parties shall strictly comply with their confidentiality obligations.

申请人(本人/监护人)正楷签名：
Signature of the Applicant（Insured/ Guardian）:

申请日期：
Date of application:

医疗信息-此处由诊疗医师填写

Medical information – to be completed by qualified medical practitioner

出险类型Type of event： □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):

该患者以前是否遭受过相同或类似症状？ Has the patient had the same or similar symptoms?

□ 是 Yes □ 否 No

若是，请提供详细情况 If yes, please provide details：

请提供该患者此次就诊的主要病情 Please describe the illness, injury or symptom of the patient for this consultation：

请提供该病情 / 受伤情况的诊断结论 Please provide the diagnosis or the nature of the illness, injury or symptom：

请提供治疗详情 Please describe the treatment:

该患者是否需复诊 Does the patient need a follow-up visit?

□ 是 Yes □ 否 No

若是，请提供复诊日期（年 / 月 / 日）IF yes, when (YY/DD/MM)?

在您看来，该病情的医疗状况是 In your opinion, is this condition：

□急性的 Acute disease □慢性的 Chronic disease □慢性疾病急性发作 Acute attack of chronic disease

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： Attending practitioner's signature:	日期（年/月/日）： Date (YY/MM/DD)