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關愛一生及康健保醫療保險計劃 - 可賠償金額估算申請表
ICARE MEDICAL INSURANCE PLAN / HEALTH GUARD HOSPITAL CARE BENEFIT PLAN - APPLICATION FORM FOR CLAIMABLE AMOUNT ESTIMATE

保單號碼 Policy No. | | | | | | | | | | |

第二部分 - 主診醫生報告書 (由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II - ATTENDING PHYSICIAN STATEMENT (To be completed by attending physician at the Insured / Policyholder / 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 醫院/診所名稱 Name of Hospital /Clinic _____

5 醫院/診所地址 Address of Hospital /Clinic _____

6 預計入院/手術日期 Expected Date of Admission/Surgery 年 Year ____ 月 Month ____ 日 Day ____

7 病人家庭醫生姓名 Patient's Family Doctor Name _____

8 預計留院日數 Estimated length of stay _____

9 住院病房級別或日間中心 Class of Ward / Day case ☐ 日間中心 / 診所 Day Centre/Clinic ☐ 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 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. _____

5 根據你的評估及意見，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？ Given the condition of the patient, is it possible to provide this treatment on an outpatient basis?

☐ 是 Yes ☐ 否 No 如不可以，請提供原因: If "No", please explain _____

6 是次病況是否為復發性/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:

年 Year ____ 月 Month ____ 日 Day ____

7 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: _____

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8 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 physician. ☐ 是 Yes ☐ 否 No

轉介醫生姓名 Name of the referring physician

轉介醫生地址 Address of the referring physician

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

(預計費用只作參考，最終收費視乎病人實際接受的治療、程序及服務而定) (The estimated charges are for reference only. Final payments are subject to charges incurred from treatment, procedures and services performed)

1 治療計劃或手術名稱 Treatment plan or Surgical procedure name (請提供每項手術名稱 Please provide the name of each surgery)

麻醉 Anesthesia

☐ 全身麻醉 G.A. ☐ 局部麻醉 L.A. ☐ 監測麻醉 M.A.C

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 是次提供的治療、治療程序、檢測是否為尚未能確定成效或屬實驗性質或仍在試驗階段的治療? Has the treatment, procedure or test not yet been established as being effective or is experimental or is in trial stage?

☐ 是 Yes ☐ 否 No

如是，請詳述並提供原因 Please provide details:

4 治療預計費用 Cost estimation of treatment:

住房及膳食費 Room and board	HK$	每日 Per Day
主診醫生巡房費 Attending physician's 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) Anaesthetist's Fee(with breakdown; if any)	HK$	
手術室費用 Operating Theatre Fee	HK$	
雜項開支費 Miscellaneous Charges	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. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

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。本人已向病人解釋上述預算費用，並徵得其同意。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. I have explained to the patient the details of the above estimated charges and have sought his / her agreement.

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