

## 團體住院及手術賠償申請表 GROUP HOSPITALIZATION & SURGICAL CLAIM FORM

團體保單號碼 Policy No.

**第二部份 – 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'S STATEMENT** To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

**A. 病人資料 PARTICULARS OF PATIENT**

|                         |                               |   |                                             |
|-------------------------|-------------------------------|---|---------------------------------------------|
| 病人姓名<br>Name of patient | 病人年齡/性別<br>Age/sex of patient | / | 病人身份證/護照號碼<br>I.D / Passport No. of patient |
|-------------------------|-------------------------------|---|---------------------------------------------|

**B. 診治資料 CONSULTATION DETAILS**

|   |                                                                                                                                           |                                        |         |       |
|---|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------|-------|
| 1 | 病人之醫療記錄可追溯至 We can trace the medical record of patient back to                                                                            | 年 Year                                 | 月 Month | 日 Day |
| 2 | 首次出現病徵日期或意外發生日期 Date of the accident occurred or symptoms first appeared                                                                  |                                        |         |       |
| 3 | 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness                                                           |                                        |         |       |
| 4 | 病人最後月經日期(只適用於生育保障)Date of last menstruation (Only applicable for maternity benefit)                                                       |                                        |         |       |
| 5 | 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                                                        |                                        |         |       |
| 6 | 如因意外住院，請提供意外詳情 For hospitalization due to accident, please provide accident details                                                       |                                        |         |       |
| 7 | 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 doctor. |                                        |         |       |
|   | 轉介醫生姓名 Name of the referring doctor                                                                                                       | 轉介醫生地址 Address of the referring doctor |         |       |

|   |              |                      |
|---|--------------|----------------------|
| 8 | 診斷 Diagnosis | 國際疾病分類編碼 ICD 10 Code |
|   |              |                      |
|   |              |                      |
|   |              |                      |

**C. 住院及手術資料 HOSPITALIZATION & SURGICAL DETAILS**

|   |                                             |                      |         |       |
|---|---------------------------------------------|----------------------|---------|-------|
| 1 | 醫院/診所名稱 Name of hospital/clinic             | 年 Year               | 月 Month | 日 Day |
|   | 入院/門診手術日期<br>Date of admission/day surgery  |                      |         |       |
|   | 出院日期<br>Date of discharge                   |                      |         |       |
|   | 入住及離開深切治療部<br>Period in Intensive Care Unit |                      |         |       |
| 2 | 手術資料 Surgical Procedure Details             | 手術日期 Date of surgery |         |       |
|   | 手術名稱 Name of the Surgical Procedure         | 醫療服務術語編碼 CPT Code    |         |       |
|   |                                             |                      |         |       |
|   |                                             |                      |         |       |



**C. 住院及手術資料 (續) HOSPITALIZATION & SURGICAL DETAILS (Continued)**

- 3 住院/手術期間之治療、檢查及其結果、有否任何併發症及出院/手術後之覆診或跟進計劃 Treatments, investigation procedures, results, and/or any complications during hospitalization/surgery and post-hospitalization/post-surgery follow up plan..

- 4 病人在入院前/手術前連續三個月曾否就此疾病接受治療或求診？如有，請提供相關詳情。  
Had the patient been treated or consulted for this condition in past 3 consecutive months prior to hospitalization/ undergone surgery? If yes, please provide details.

☐ 是 Yes ☐ 否 No

醫生姓名 Name of the physician

醫院名稱 Name of hospital

治療日期 Treatment date

治療詳情 Treatment details

- 5 病人有否於住院期間請假外出？如有，請列明外出及返回之日期及時間。 Has the Insured taken any home leave during the hospital confinement? If yes, please state the starting and ending date and time.

**D. 閣下之專業意見 PROFESSIONAL COMMENT**

- 1 是次檢查、治療及住院日數(如有) 是否與上述診斷有直接關係而且是醫療所需及由醫生建議？  
Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were medically necessary and recommended by you? ☐ 是 Yes ☐ 否 No  
如否，請詳述。If No, please provide details (如：是否由病人要求住院? E.g. Was the hospitalization requested by patient?)

- 2 該檢查及手術可否在門診 / 日間手術中心進行? Can the medical test(s) and the operation procedure be done on an outpatient basis / at day surgery centre? ☐ 是 Yes ☐ 否 No  
如否，請註明臨床風險、須留院的醫院原因及詳述現時健康狀況 (合併症): If No, please indicate the clinical risk(s), medical reason(s) for hospitalization and current Health Status (Co-morbidity):

- 3 手術是否必須在全身麻醉下進行? The surgery could only be performed under general anesthesia?  
☐ 是 Yes ☐ 否 No  
如手術在監察下麻醉進行，請註明住院原因 For surgery under Monitored Anesthesia Care, please specify the reason for hospital stay.

- 4 是次檢查、治療及住院是否緊急個案? Is it a case of emergency?

☐ 是 Yes ☐ 否 No

如是，請詳述並提供原因 Please provide details:

- 5 是次病症或受傷是否(1)復發個案，或(2)任何慢性疾病/ 嚴重疾病之併發症，或(3)與過往其他病況有關？如是，請提供有關診治日期及治療詳情。Is the condition (1) a recurrent episode or (2) a complication of any chronic illness/ major disease or (3) related to any previous conditions? If yes, please provide date of diagnosis and treatments details.

☐ 是 Yes ☐ 否 No 診治日期 Date of diagnosis/treatments 年 Year 月 Month 日 Day

詳情(包括診斷/治療/檢查及結果) Details (including diagnosis/ treatments/ investigations and results)

## D. 閣下之專業意見(續) PROFESSIONAL COMMENT (Continued)

6 是項疾病之根本主因 What is the underlying cause of such illness?

7 病情預測及復發之可能 The prognosis of the condition and any possibility of having a relapse?

8 請選出與是項疾病有關之狀況。Is the illness associated with the following?

- ☐ 先天性疾病 Congenital condition    ☐ 自殘 Self-inflicted injury    ☐ 不育或絕育 Infertility or sterilization    ☐ 精神紊亂 Mental disorder  
☐ 濫藥或酗酒 Abuse of drugs or alcohol    ☐ 性病 Venereal disease    ☐ 視力矯正 Corrective aids or treatment of refractive errors    ☐ 康復/療養 Rehabilitation/convalescence  
☐ 整容或整形治療 Cosmetic or plastic surgery    ☐ 發育異常 Developmental abnormality    ☐ 參與危險性運動/活動 Hazardous sport / activity    ☐ 遺傳性疾病 Hereditary condition  
☐ 一般身體檢查/防疫注射 Body check vaccination & immunization injections    ☐ 愛滋病或人體免疫缺陷病毒感 染 AIDS or HIV related illness    ☐ 懷孕，請說明預產期 Pregnancy, please provide expected date of delivery  
☐ 其他疾病，請說明 Other disease, please specify    ☐ 以上皆否 None of the above

## E. 其他醫療病史 OTHER MEDICAL HISTORY

1 請選出病人過往有否以下病症/習慣。Does the patient have any medical history or habit as indicated below?

- ☐ 哮喘 Asthma    ☐ 心臟病 Cardiac problem    ☐ 糖尿病 Diabetes Mellitus  
☐ 乙型肝炎 Hepatitis B    ☐ 高血壓 Hypertension    ☐ 曾接受手術 Previous operation  
☐ 濫藥 Drug abuse    ☐ 家族性癌症 Family history of cancer    ☐ 家族病史 Unfavorable family history  
☐ 以上皆沒有 None    ☐ 其他疾病，請說明 Other disease, please specify

2 該病人曾否因患上上述疾病或其他嚴重疾病接受醫生或醫院治療？如有，請說明詳情。Had the patient previously been treated or hospitalized due to the above disease or other major disease? If so, please specify details.

☐ 有 Yes    ☐ 沒有 No    診治日期 Date of diagnosis/treatments    年 Year    月 Month    日 Day

疾病 Disease

治療/住院詳情 Details of Treatment / Hospitalization

醫生姓名/醫院名稱 Name of Physician/Hospital

3 請提供飲酒/吸煙習慣詳情 Please provide details of drinking &amp; smoking habit

每日用量 (支/包/樽/罐) Daily consumption (piece/ pack/ bottle/ can)

習慣始自 Drinking/ Smoking start date since    年 Year    月 Month    日 Day

## F. 主診醫生資料 PARTICULARS OF ATTENDING PHYSICIAN

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。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.

|                                                                                      |  |                     |        |         |       |
|--------------------------------------------------------------------------------------|--|---------------------|--------|---------|-------|
| 主診醫生姓名<br>Name of Attending physician                                                |  | 資歷<br>Qualification |        |         |       |
| 地址<br>Address                                                                        |  | 聯絡電話<br>Contact No. |        |         |       |
| 主診醫生簽署及醫院/診所蓋章<br>Signature of Attending Physician<br>and Stamp of Hospital / Clinic |  | 日期<br>Date          | 年 Year | 月 Month | 日 Day |
|                                                                                      |  |                     |        |         |       |