

指引

- 門診索償應於診症/治療後**90日**內遞交申請(除保單內另有註明)。
- 請附上由醫生簽發的收據正本或由其他保險公司發出的收據核實副本(適用於已獲其他保險公司賠償之申請)。每張收據必須列明以下資料:
 - 就診者姓名 • 診症日期 / 治療日期 • 病症名稱
 - 收費項目說明 • 醫生簽署及蓋章
- 除保單內另有註明外,物理治療師及脊椎治療師治療· X光檢驗及化驗均須出示主診醫生的推薦書。專科門診的推薦書要求詳情·請參閱保障表或成員指引(如有)。推薦書在發出日起計6個月內方為有效。
- 診所以外購買藥物費用之賠償須附主診醫生之處方及藥房之收據正本。
- 中醫治療索償必須遞交正本中醫收據及藥方(處方蓋)。
- 您可隨時經由 <https://www.fwd.com.hk> 登入富衛客戶網上服務查閱閣下已被處理的索償紀錄(只適用於團體醫療保單)。

Instructions

- Claim for Outpatient Benefit must be submitted **WITHIN 90 days** from the date of consultation/treatment (unless otherwise specified in the policy).
- Please attach the original receipts issued by the doctor or certified true copy of receipts issued by other insurers (applicable to such claim already reimbursed by another insurer). Each receipt **MUST** state the following information:
 - Full name of patient • Date of consultation/treatment • Diagnosis
 - Breakdown of charges • Doctor's signature & official stamp
- Unless otherwise specified in the Policy, doctor's referral letter is required for Physiotherapist's & Chiropractor's Treatment, Diagnostic X-ray and Laboratory Test. Details of the referral letter requirement for Specialist consultation, please refer to Benefit Schedule/membership guide (if any). The referral letter is valid for six months from date of issuance.
- For claim in respect of the purchase of prescribed medicines or drugs outside clinic, please submit both Doctor's prescription and original receipts from pharmacy.
- For Chinese Medicine Practitioner's claim, please submit both original receipts and prescription.
- You may login our FWD Customer Online Service via <https://www.fwd.com.hk> to check your processed claim records (only applicable for group medical policy).

保單持有人名稱: Name of Policyholder :	保單號碼: Policy No. :
僱員/成員姓名(英文): Name of Employee/Member (English) :	
僱員編號 Employee Code : (如適用 if applicable)	電話號碼: Contact No.:
就診者姓名(英文): Name of Patient (English):	就診者身份證/護照號碼: ID Card/Passport No. of Patient :
擬申請之索償類別 (請選擇並加√號) Proposed Claim Type (Please tick as appropriate): <input type="checkbox"/> 普通科 General <input type="checkbox"/> 專科 Specialist <input type="checkbox"/> 物理治療師及脊椎治療師 Physiotherapist's & Chiropractor's Treatment <input type="checkbox"/> 中醫或跌打 Chinese Herbalist/Bonesetter <input type="checkbox"/> X光檢驗及化驗 Diagnostic X-ray and Laboratory Tests <input type="checkbox"/> 出院後之治療費 Post Hospitalisation Treatment (住院日期 Date of Hospitalisation: 由From _____ 至 To _____) <input type="checkbox"/> 其他 Others _____ 附上正本收據總數 No. of original receipt(s): _____	
若診治因意外引起, 請提供: If the consultation/treatment was due to accident, please provide : 意外發生日期 Date of Accident : _____ 時間 Time : _____ 地點 Place : _____ 經過 Brief Description : _____	
有關此次索償, 閣下有否申請其他保險索償? Are you making any other insurance claim for this claim? <input type="checkbox"/> 沒有 No 在任何情況下不設退回正本收據。如需副本作其他用途, 請於遞交前自行影印收據。Original receipt will not be returned in any circumstances. If copy of receipt for other purpose is needed, please make a copy before submission. <input type="checkbox"/> 有 Yes (必需填寫 Required information) 保險公司名稱 Name of the Insurance Company : _____ 保單號碼 Policy No.: _____ 保單類別 Type of Policy : _____ 請注意只退回附有索償餘額之正本收據以申請其他索償, 如需副本作其他用途, 請於遞交前自行影印收據。 Please note that only the original receipt with unpaid claim balance will be returned for applying other claims. If copy of receipt for other purpose is needed, please make a copy before submission.	
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就診者簽署 Signature of Patient :	日期 Date :
(若就診者為小童, 則可由家長/合法監護人簽署 If the patient is a minor, the patient's parent/legal guardian can sign on his/her behalf)	