醫療保險 - 門診福利索償表

Medical Insurance - Outpatient Benefit Claim Form

指引

(1) 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)。

(2) 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

(3) 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。

(4) 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。

(5) 中醫治療索償必須遞交正本中醫收據及藥方 (處方盞)。

(6) 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

(1) Claim for Outpatient Benefit must be submitted **WITHIN 90 days** from the date of consultation/treatment (unless otherwise specified in the policy).

(2) 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

(3) 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.

(4) 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.

(5) For Chinese Medicine Practitioner's claim, please submit both original receipts and prescription.

(6) 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):

☐ 普通科 General ☐ 專科 Specialist ☐ 物理治療師及脊椎治療師 Physiotherapist's & Chiropractor's Treatment

☐ 中醫或跌打 Chinese Herbalist/Bonesetter ☐ X 光檢驗及化驗 Diagnostic X-ray and Laboratory Tests

☐ 出院後之治療費 Post Hospitalisation Treatment (住院日期 Date of Hospitalisation: 由From _____ 至 To _____)

☐ 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?

☐ 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.

☐ 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.

聲明及授權 DECLARATION & AUTHORISATION :

本人現聲明上述所填報的資料正確無訛。本人授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關本人傷患之病歷(包括但不限於診症、診斷性檢驗結果、藥方或治療資料)給予富衛保險有限公司 / 富衛人壽保險（百慕達）有限公司（於百慕達註冊成立之有限公司）(「富衛」)或其已獲授權之代理人。此授權書之副本與正本具同等效力。

本人現確認本人已閱讀、明白及同意富衛的收集個人資料聲明。本人同意富衛不時以任何方式收集、製作、匯編或保留任何關於本人的個人資料或保單的其他資料，可根據收集個人資料聲明使用。本人同意富衛可能將本人個人資料轉移，披露予收集個人資料聲明所載的資料承讓人 (不論在香港境內或境外者)，或讓其查閱或與其共同使用。本人知悉收集個人資料聲明的最新版本可於 https://www.fwd.com.hk 下載及可向富衛索取。

I hereby declare that the above information given is true and correct. I further authorize any physician, hospital, insurance company or organisation to furnish part of or all medical history (including but not limited to information in respect of consultations, diagnostic test results, prescriptions or treatment) with respect to any illness or injury of me to FWD General Insurance Company Limited / FWD Life Insurance Company (Bermuda) Limited (Incorporated in Bermuda with limited liability) ("FWD") or its authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original.

I confirm that I have read, understood and agreed to the Personal Information Collection Statement ("PICS") of FWD. I agree that any personal data and other information relating to me or my policy(ies) collected, generated, compiled, or held by FWD by any means from time to time may be utilized in accordance with the PICS. I agree that FWD may transfer, disclose, grant access to or share my personal data within or outside Hong Kong to the types of transferees set out in the PICS. I understand that the updated version of the PICS is available for download https://www.fwd.com.hk and is made available upon request.

_____ _____

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)