Cigna HealthFirst Series
Hospital Pre-Admission Form
信諾醫療保系列住院審批申請書

Quality HealthCare Medical Services Limited (QHMS) is a service provider appointed by Cigna to provide services for Cigna HealthFirst Series, including the administration of claims. Please call the QHMS managed Cigna HealthFirst Hotlines for any claim related enquiry. Tel: (852) 8203 2202 Fax: (852) 2534 0223

Please submit your completed form and related medical documents to QHMS Claims Department (Third Party Administration), Quality HealthCare Medical Services Limited, 3/F, Skyline Tower, 39 Wang Kwong Road, Kowloon Bay, Kowloon.

This form must be completed in full for us to process the application for the "Guarantee of Payment" .

信諾委任卓健醫療服務有限公司（卓健）為信諾醫療保系列服務商，其服務包括處理索償事務。如有關任何索償事項查詢，請致電卓健提供之信諾醫療保專線。

電話: (852) 8203 2202 傳真: (852) 2534 0223 請遞交已填妥之表格及有關之醫療文件至九龍灣宏光道39號宏天廣場3樓卓健醫療服務有限公司卓健醫療理賠部(TPA)

您必須填妥此表格所需的全部資料，以便辦理「付款保證」之申請。

Part A 第一部份 – To Be Completed By Policyholder 由保單持有人填寫

Name of Policyholder 保單持有人姓名 English 英文 Family Name 姓 _____ Given Name 名 _____ Chinese 中文 _____

Policy No. 保單編號 _____ Contact No. (Tel / Fax) 聯絡號碼 (電話 / 傳真) _____

Declaration & Authorization 聲明及授權 – To Be Signed By Insured 由受保人簽署

I hereby declare all the statements to all questions above, whether or not written by my own hand are to the best of my knowledge, belief, complete and true.
I authorize any medical practitioner, hospital, pharmacy, insurance company, police station, employer, or other organization or persons that have any records, medical history or knowledge of me and/or the insured, to release full particulars of such information to Cigna Worldwide Life Insurance Company Limited and Cigna Worldwide General Insurance Company Limited (collectively, "Cigna") or their appointed representatives/agents for the purposes of assessing or processing this application or claims and subsequent services/customer satisfaction survey. To avoid any uncertainty, this authorization shall bind all my/the insured's successors, assignees, executors and administrators and shall remain valid notwithstanding my/the insured's death or incapacity. A copy of this Declaration & Authorization shall be deemed to be valid as the original.
I further agree that any personal information collected or held by Cigna (whether contained in this application or otherwise obtained) is provided and may be held, used, disclosed and transferred by Cigna to any related companies/organizations or any selected parties (within or outside Hong Kong, including insurance intermediary acting on my/the insured's behalf, reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application or claims and providing subsequent services, data matching, and to communicate with me/the insured for such purposes. I have the right to obtain access and to request correction of any personal information held by Cigna. Such request can be made to Cigna's Data Protection Officer.

本人特此聲明一切陳述，不論是否本人親手所寫，就本人所知所言，均為正確無訛及完整。
本人茲授權任何醫生、醫院、藥房、保險公司、警察局、僱主、任何機構及人士，將已經存錄或準備存錄的本人/受保人之醫療、病歷及其他資料給予信諾環球人壽保險有限公司及信諾環球保險有限公司(統稱"信諾") 或其代表，作為評估或辦理此申請書或索償和售後服務/意見調查之用。為免任何疑問，本授權書對本人/受保人之繼承人、受讓人、遺囑執行人及遺產管理人均具有約束力。即使本人/受保人死亡或無行為能力，本授權仍具效力。本授權之副本及正本具同樣效力。
本人謹此聲明及同意信諾收集或存錄有關之個人資料(無論載於本申請書內或從其他途徑所獲取的)，並可保留、使用、透露、及轉傳該等資料給任何有關公司/機構或被選定的團體(本港或海外，包括代表本人/受保人的保險中介人、再保公司、賠償調查公司及同業協會或聯會)，以辦理此申請書、索償及售後服務、資料核對，並作為知會本人/受保人之用。本人有權向貴公司查閱及要求更正任何已存錄之個人資料，而有關申請可向信諾個人資料保護專員提出。

Signature of Insured /Policyholder (if insured is below 18 years old) 受保人 / 保單持有人簽署 (如受保人未滿18歲)	
Date Signed 簽署日期	
Name of Insured / Policyholder (in block) 受保人 / 保單持有人姓名(請以正楷書寫)	HK Identity Card No. of Insured / Policyholder 受保人 / 保單持有人香港身份證號碼

Shortfall Collection Credit Card Authorization Form 繳付差額費用之信用卡授權書

If the amount paid by QHMS to the hospital exceeds the eligible claims arising from this hospitalization, this Form authorizes QHMS to collect the shortfall amount from the following credit card account. The credit cardholder should be the Policyholder of this policy. The shortfall collection notice will be sent to you 5 days prior to the collection.
如卓健直接支付予醫院的費用超出是次住院應付的賠償額，此授權書將授權卓健從以下信用卡帳戶收取此差額。持卡人必須為此保單之持有人。卓健將於收取差額費用5天前郵寄結欠付款通知書通知閣下。

Credit Card Authorization Form 信用卡付款授權書 (this section must be completed 此部份必須填寫)

Cardholder's Name 持卡人姓名	HKID Card No. 持卡人香港身份證號碼	Signature of Cardholder (must be the same as that on the Credit Card) 持卡人簽署 (須與信用卡上簽名相同)
Credit Card Account No. 信用卡號碼	Credit Card Expiry Date 信用卡到期日 (MM/YY 月/年)	
I hereby authorize and direct Quality HealthCare Medical Services Limited to debit the outstanding shortfall due from my credit card account 本人授權及指示卓健醫療服務有限公司從本人信用卡戶口扣除到期之差額費用		X
Contact co. 聯絡號碼	Date日期	Date 日期 / / (年 / 月 / 日 YY/MM/DD)

Part B 第二部份 — To Be Completed By The Attending Physician / Surgeon 由主診醫生填寫

Patient Name 病人姓名 _____ HKID Card No. 香港身份證號碼 _____ Age 年齡 _____ Sex 性別 _____ M / F 男 女 _____

Medical History 病歷

1. Diagnosis / symptoms 診斷 / 病徵
   i. Chief complaint 主要申訴: _____
   ii. Prior to this consultation, did patient first consult you for the related signs and symptoms? And when was the first consultation?
   在是次求診日期時，病人有否在台端執業之診所診治有關上述病況之紀錄?如有，病人始自何時求診?
   ☐ NO 否 ☐ YES, the first consultation was since 有，第一次求診日期始自 _____ / _____ / _____ (年 / 月 / 日 YY/MM/DD)

2. Onset date of the symptoms/ condition:
   發病日期:
   _____ / _____ / _____ (年 / 月 / 日 YY/MM/DD)

Hospitalization Details 住院詳情

Hospital Name 醫院名稱 _____ Class of bed: Ward / Semi-private / Private / Others: 住房級別: 普通病房 / 半私家 / 私家 / 其他: _____

Admission date 入院日期 _____ / _____ / _____ (年 / 月 / 日 YY/MM/DD) Expected Length of Stay 預計住院日數 _____ day(s) 日 Inpatient physician fee 住院醫生費 HKD 港幣 _____ /day /日

Treatment Details 治療詳情

Surgery / treatment required 建議之手術 / 治療： _____ Reason for this hospitalization 住院原因： _____

Lab tests / Imaging / other diagnostic investigation required 建議之化驗 / 影像檢查 / 其他診斷性檢查： _____ Anaesthesia麻醉: G.A.全身麻醉 ☐ L.A. 局部麻醉 ☐

Surgical fee 手術費: HKD 港幣 _____

If you have recommended the patient for specialist's opinion (other than attending Physician), please give specialist name and nature of treatment provided:
如有轉介至專科診治，請提供專科醫生之姓名及治療詳情:

Physician's Information 醫生資料

Physician's name 醫生姓名 _____ Signature of Physician and Chop 醫生簽署及印章 _____

Contact no. 聯絡號碼 _____ (Tel 電話) _____ (Fax 傳真) Date 日期 _____

HFGOP/ OCT 2012

How to apply Guarantee of Payment Letter (GOP)* for your hospital confinement?

若需要住院，如何申請住院付款保證信* ？

Call Cigna HealthFirst Hotline for Pre-admission arrangement
(852) 8203 2202

致電信諾醫療保專線 (852) 8203 2202

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Complete the Hospital Pre-admission Form and send to QHMS
by fax on (852) 2534 0223 / post / in person #

填妥住院審批申請書，然後傳真至卓健 (852) 2534 0223 / 郵遞 /親身交回卓健 #

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QHMS will send a Guarantee of Payment (GOP) Letter to
attending hospital

醫院將會收取卓健發出的住院付款保證信

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Upon admission, present the Cigna HealthFirst Medical Card and HKID Card
to hospital for registration

入院時，向醫院出示信諾醫療保醫療卡及身份證以作登記

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You will receive the Claim Settlement Advice (with shortfall details if applicable) 10
working days^ after QHMS receiving full documentation from hospital.

由收妥醫院提交齊備文件後,卓健將於10個工作天^內通知保單持有人有關的賠償詳情及繳付有關之差額費用(如適用).

* Approval of this benefit is subject to the terms and conditions of the relevant policy provisions and the acceptance of the "Guarantee of Payment Letter" by the hospitals
此保障之批核須受有關保單條款及細則約束及有關醫院是否接受「付款保證信」。

\# You will be required to provide treatment information and authorize QHMS to collect shortfall of medical expenses, if any, from your credit card account
您須提供治療資料及授權卓健從您的信用卡帳戶收取醫療費用的差額 (如有)

^ The actual date of claims notification depends on the submission of required documents from hospital
卓健通知保單持有人有關賠償的所需日數會因應醫院遞交賠償所需文件而有所不同

Cigna Worldwide Life Insurance Company Limited 信諾環球人壽保險有限公司 Cigna Worldwide General Insurance Company Limited 信諾環球保險有限公司