NOW HEALTH INTERNATIONAL | API 亚太财险 Asia-Pacific P&C

全球保预先授权申请表
WorldCare pre-authorisation request form

您向我们提交预先授权理赔时，请将此申请表格连同填妥的理赔申请表及任何支持文档一同送回。

本表格应由您的主治医生填写。

请通过您的保险中介或直接向时康管理顾问（上海）有限公司寄送您填妥的表格，转交：亚太财产保险有限公司，中国上海市虹口区吴淞路218号宝矿国际大厦11楼1103室–1105室，邮编：200080。您亦可将其扫描及电邮至ChinaService@now-health.com或传真至+(86) 400 077 7900。

When submitting a pre-authorised claim to the insurer, please return this form with a completed claim form and any supporting documents.

This form should be completed by the insured member's treating medical practitioner.

Please send the completed form to the insurer via the insured member's intermediary or direct to Asia-Pacific Property & Casualty Insurance Co., Ltd., c/o: Now Health International (Shanghai) Limited, Room 1103–1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China. The insured member can also scan and email it to ChinaService@now-health.com or fax it to +(86) 400 077 7900.

第一部分：医疗机构详情
Section 1: Medical facility details

医疗机构： Medical facility:		
电子邮件： Email:	传真： Fax:	电话号码： Telephone number:
主治医生： Treating medical practitioner:		
电子邮件： Email:	传真： Fax:	电话号码： Telephone number:
患者姓名： Patient name:		
会员编号： Membership number:	出生日期（日/月/年）： Date of birth (dd/mm/yyyy): / /	

第二部分：审批请求（请勾选适当方框）
Section 2: Approval request (please tick appropriate box)

选择性治疗 Elective Treatment		
住院 In-Patient ☐	日间留院 Day-Patient ☐	门诊手术 Out-Patient surgery ☐
物理治疗 Physiotherapy ☐	正电子放射断层扫描 PET ☐	生育 Maternity ☐
美国境内的治疗 USA Treatment ☐		

其他治疗 Other Treatment		
紧急入院 Emergency admission ☐	请提供病情和治疗方面的完整细节： Please provide full details of nature of illness and treatment:	
事故 Accident ☐	请提供事故的起因、日期和地点详情： Please provide details of cause, date and place of accident:	
是否会涉及第三方？如果是，请提供详情： Was a third party involved? If yes, please give details:		
遗体运送 Mortal remains ☐	精神病治疗 Psychiatric treatment ☐	艾滋病 AIDS ☐
其他 Other ☐ 请说明： Please specify:		

第三部分：治疗详情
Section 3: Treatment details

需治疗疾病的完整细节：
Full details of condition requiring treatment:

患者首次发觉此疾病的任何体征或症状（日/月/年）：
Date the patient first became aware of any signs or symptoms of this condition (dd/mm/yyyy): / /

患者首次针对此疾病向医生说明的日期（日/月/年）：
Date on which the patient first presented to any doctor for this condition (dd/mm/yyyy): / /

基本病因（若知道的话）：
Underlying cause (if known):

临时诊断： Provisional diagnosis:	ICD 10 代码： ICD 10 code:
治疗日期： Date of treatment (dd/mm/yyyy): / /	预计住院时间： Estimated length of stay:
建议入院日期（日/月/年）： Proposed admission date (dd/mm/yyyy): / /	建议出院日期（日/月/年）： Proposed discharge date (dd/mm/yyyy): / /

建议治疗/手术的完整细节：
Full details of proposed treatment/surgery:

治疗程序代码：
Procedure code: (e.g. CPT, CCSD, DRG etc.)

请提供包括币种在内的总预估费用，并根据以下列出的内容提供计划服务的细目：
Please provide total estimated costs including currency with breakdown of planned services as detailed below:

外科医生费用： Surgeon's fee:	病房级别： Room class:
麻醉师费用： Anaesthetist's fee:	普通病房费率 x 日数 = Ward rounding fee x no. of days =
手术费用： Operation theatre cost:	标准病房费率 x 日数 = Standard room rate x no. of days =
其他费用： Additional/Miscellaneous charges:	ICU 费率 x 日数 = ICU rate x no. of days =

服务套餐费率：
Package rate:

总预估费用：
Total estimated charges as per above breakdown:

第四部分：医生声明
Section 4: Medical Practitioner Declaration

医生声明：
Medical Practitioner declaration:
谨此声明，本人是患者的医生，就本人所知及所信，所填资料均正确无误。
I declare that I am the patient's medical practitioner, and that the particulars given are, to the best of my knowledge, true and correct.

正楷签名：
Print name:

签名：
Signature:

日期（日/月/年）：
Date (dd/mm/yyyy): / /

官方印章：
Official stamp:

如果需要其他治疗，或治疗费用和/或预计住院时间超出了许可范围，请通过电子邮件或致电+(86) 400 077 7500通知我们。
Please notify the insurer by email or phone on +(86) 400 077 7500 if additional treatment is required, if the cost of treatment and/or if the estimated length of stay is extended beyond the approved limit.

第五部分：病人声明及授权
Section 5: Patient declaration and authorisation

资料保障

在审核您的理赔申请的过程中，保险人将收集到部分与被保险人相关的信息。该信息将被用于确认您的保障范围、管理已签发的保险计划以及处理赔案。被保险人的信息可能因为上述目的而被转交至核保人、医生、医疗援助公司及理赔管理人。

任何协助管理您的保险计划的第三方亦需承担相同的保密责任。除上述者外，被保险人的姓名及联系资料将不会向其他组织披露。

如果保险赔偿金为非人民币，本人委托保险人办理以所给付的保险金金额为限的购汇业务。

本人明白时康管理顾问（上海）有限公司为保险人委托之保单管理服务商，特在此同意及授权保险人将应支付给本人的保险金先支付给时康管理顾问（上海）有限公司，然后由时康管理顾问（上海）有限公司再把保险金支付给本人。

对于发生在事先约定的医疗机构内，针对特定的或本保险人已经事先担保的医疗项目，本人在此授权该医疗机构或预先指定的第三方代表本人向保险人索赔，保险人应该直接支付给该医疗机构或指定的第三方。

Data protection

The insurer will collect certain information about the insured member in the course of considering claims. This information will be processed for the purposes of underwriting the insured member's insurance coverage, managing any policy issued and administering claims. The insured members' information may be passed to underwriters, medical practitioners, medical assistance companies and claims administrators for these purposes.

The same duty of confidentiality is required of any third parties to whom the administration of the insured member's policy may be subcontracted. The insured members' name and contact details will not be disclosed to other organisations (except as stated above).

If the chosen claim settlement currency is not RMB, I authorise Asia-Pacific Property & Casualty Insurance Co., Ltd. to purchase foreign exchange for claim reimbursement up to the policy benefit maximum.

I understand that Now Health International (Shanghai) Limited has been appointed by Asia-Pacific Property & Casualty Insurance Co., Ltd. to be the policy administrator for this policy. I hereby agree and authorise Asia-Pacific Property & Casualty Insurance Co., Ltd. to settle my claim payment to Now Health International (Shanghai) Limited first and then remit the claim payment to me accordingly.

For Direct Billing cases or where a guarantee of payment has been put in place, when medical treatment has been received by a pre-appointed provider, I hereby authorise the provider or pre-appointed third party to bill my insurance company, who will make payment of any benefit directly to the provider or pre-appointed third party.

第五部分：病人声明及授权
Section 5: Patient declaration and authorisation

声明

特此声明，本人是病人/病人的监护人*（如果病人小于16岁）（*请删去不适用者）。

本人希望获取赔偿，并声明就本人所知及所信，所提供资料均真实、正确及完整，即使并非本人亲笔书写。

本人明白，本人为欺诈或企图欺诈保险人或其代理人而提供错误、不完整或有误导性的事实或数据属违法。惩罚包括监禁、罚款、拒绝赔偿、取消保单及法定损害赔偿。

本人同意上述资料保障声明，并明白该理赔申请应符合保险人保险计划的条款及条件。

本人同意保险人或其代理人必要时可从医生处查阅医疗报告，以便保险人或其代理人可以处理本人的理赔要求。

本人（不）*希望在医疗报告送达保险人或其代理人之前查看医疗报告。*如果被保险人希望查看报告，请删除“不”字。

本人谨同意授权治疗过本人或向本人提供过建议的任何医生和/或医院向保险人或其代理人提供其可能要求的与该理赔相关的任何资料。

填妥并由病人与医生签名后（当需要时），请将该表及随附的发票和付款收据寄回至时康管理顾问（上海）有限公司，转交：亚太财产保险有限公司，中国上海市虹口区吴淞路218号宝矿国际大厦11楼1103室–1105室，邮编：200080。

本人已阅读第五部分的声明。

本人同意上述声明并明白理赔乃根据亚太财产保险有限公司全球保个人与家庭医疗保险的条款及条件提供。

本人同意如果预先授权申请表的中英文内容存在不一致时，以中文文本的内容为准。

Declaration

I hereby declare that I am the patient/patient's guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim benefit and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information to Asia-Pacific Property & Casualty Insurance Co., Ltd. or its appointed representative for the purpose of defrauding or attempting to defraud Asia-Pacific Property & Casualty Insurance Co., Ltd. or its appointed representative. Penalties may include imprisonment, fines, denial of coverage, rescission of benefits and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the Asia-Pacific Property & Casualty Insurance Co., Ltd. policy.

I consent to Asia-Pacific Property & Casualty Insurance Co., Ltd. or its appointed representatives to seek medical reports if needed from my medical practitioner, so that Asia-Pacific Property & Casualty Insurance Co., Ltd. or its appointed representative can deal with my claim.

I do (NOT)* wish to see the medical report before it is sent to Asia-Pacific Property & Casualty Insurance Co., Ltd. or its appointed representative. *Delete the word NOT if you wish to see the report.

I hereby consent to authorise any doctor and/or hospital who has treated or advised me to provide Asia-Pacific Property & Casualty Insurance Co., Ltd. or its appointed representative with any information they may require in connection with this claim.

When completed and signed by the patient and medical practitioner (when appropriate), please return this form and the accompanying invoices and payment receipts to Asia-Pacific Property & Casualty Insurance Co., Ltd., c/o: Now Health International (Shanghai) Limited, Room 1103–1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.

I have read the declaration in Section 5.

I agree to the declaration and understand that any claim for Benefit is in accordance with the terms and conditions of the Asia-Pacific Property & Casualty Insurance Co., Ltd. policy.

I agree that if there is any inconsistency between the Chinese and English version of the pre authorisation form, the Chinese version will prevail.

病人签名：
Patient's signature:

日期（日/月/年）：
Date (dd/mm/yyyy):

/ /