ICBC 工银安盛人寿 ICBC-AXA LIFE

ICBC-AXA Life Pre-Authorisation Form – Non Maternity

Treating Specialist / Consultantor Hospital Insurance Office to Complete

*****To ensure efficient processing of this application please ensure the form is completed clearly and legibly*****

工银安盛人寿 保险事先授权书 – 非产科

由医疗专家/主治医师或医院保险办公室填写

*****为使申请得到迅速受理，请确保本申请书填写完整、清晰，明白无误*****

Patient's Family Name / Last Name 患者姓: First Name 名:

Patient's Date of Birth 患者出生年月日: Year年 Month月 Day日

Plan Name保险计划名称: Plan Number保险计划编号:

Member Number被保险人号码:

Patient's Contact Phone Number 患者联系电话号码:

Patient's email address (if known) 患者电子邮箱地址（如已知）:

NB: Contact details must be provided to enable us to process the pre-authorisation, failure to do so may result in delays 注意：必须提供详细联系地址，否则会延误对本事先授权书的处理.

Admission Date 入院日期: Expected Discharge Date 预期出院日:

Treatment Date (outpatient) 治疗日期 (门诊):

NB: Admission date must be (treatment date) provided before we can provide a Guarantee of Payment letter

注意：必须要有预计入院日期(治疗日期)我们才能出具支付保函。

Specialist / Consultant Name专家/主治医师姓名:

Telephone number电话号码: Fax Number传真号码:

E-mail Address电子邮箱地址:

If the patient was referred to you – please advise the name and contact details of the referring doctor.

如果病人是转介给您的，请提供该医生的姓名和详细的联络方式。

Name of Doctor 医生姓名: Contact telephone number医生电话号码:

On what date did the patient first notice signs and symptoms of this medical condition?

患者什么时候第一次发现症状? Year年 Month月 Day日

On what date did the patient first present these symptoms to you :

患者什么时候第一次向您寻求治疗? Year年 Month月 Day日

Please provide full details of patient symptoms: 请详细描述症状

Has the patient suffered from the same or similar symptoms previously 患者以前有没有出现同样或相似的症状:

Yes 有: ☐ No 没有: ☐

If yes, please provide full details 如回答有，请予以说明:

Please provide full details of medical examination findings: 请详细提供医疗检查结果
Please provide full details of medical investigations required: 请详细描述所需治疗
What is your diagnosis: Provisional: 初步诊断 Final: 最后诊断
Please provide proposed treatment plan 请提供您建议的治疗计划:
In Your opinion would you consider the medical condition to be按您的观点，此病症属于: Acute: ☐ 急性 Chronic: ☐ 慢性 Acute episode of a chronic condition: ☐ 慢性疾病急性发作 Terminal: ☐ 晚期疾病
I declare that to the best of my knowledge and belief the statements made on this claim for are full, true, and complete 我申明就我所知此次保险索赔中所述是完整的，真实的，全面的. Medical practitioner signature 医生签名: Date日期: Year年 Month月 Day日
Estimated Costs **Please provide a breakdown amount in point a-f if you do not provide package prices, or please advise the package quote in point g.** **费用概算** **如没有给您组合报价，请按以下a-f点分别列出，或者将组合报价列在 g 点**
a) Surgeon's /Doctor' s Fees手术/医生费: b) Anesthetist's Fees 麻醉师费: c) Laboratory Fees 化验室费: d) Radiology Fees放射费: e) Hospital Theatre Fees手术室费: f) Medicines/consumables 药品/医疗耗材费: g) Estimated package price if applicable 估计组合报价(如有):

Please note: If the patient is on a Moratorium Policy, we may need to obtain further details of previous medical history, before being able to approve costs for this medical treatment.Your assistance in providing this form, fully completed, **at least 48 hours** prior to discharge, is much appreciated **请注意:** 如被保险的保单不保障既往病症，在批准此次医疗费用前我们可能需要获取被保险人之前的病史。请您最迟在被保险人出院前的48小时内，协助填写完成这一表格。感谢您的协助！