



ICBC-AXA Life Pre-Authorisation Form – Maternity

Treating Specialist / Obstetrician or 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 – 产科

由医疗专家/产科医生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 被保险人会员编号:

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.

Estimated Admission Date 预计入院日:

Expected Discharge Date 预期出院日:

NB: An estimated admission date must be provided before we can provide a Guarantee of Payment letter 注意: 在我们提供支付保函之前, 必须提供一个预计的入院日期.

Specialist / Obstetrician Name 专家/产科医生姓名:

Telephone number 电话号码:

Fax Number 传真号码:

E-mail Address 电子邮箱地址:

Please advise date of LMP 末次月经日:

Year年

Month月

Day日

Please advise estimated delivery date 预计分娩日:

Year年

Month月

Day日

Please advise type of delivery 分娩种类:

Normal Vaginal Delivery 自然顺产:

C- Section 剖腹产:

If C-Section, please advise the reason 如剖腹产, 请说明理由:

Is the pregnancy a result of infertility treatment/medication, or in conception by artificial means 这次怀孕

是否因不育治疗/药物而成(包括人工受孕)? Yes 是

No 不是

If yes, please provide method of conception 如果是, 请提供受孕方法:

Does the patient suffer from any medical conditions that might put the pregnancy at risk 患者是否患有某种可能危及妊娠的疾病? Yes 是 No 不是

If yes, please specify 如回答是, 请予以说明:

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.

Obstetrician signature 产科医生签名:

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 化实验室费: | 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 所知组合报价(如有): | |