(HUATAI) Pre-certification Medical Form
华泰索赔预先批核表格

To: 致:	From: Aetna (Shanghai) Enterprise Services Co., Ltd 由: 安态(上海)企业服务有限公司
Fax No: 传真:	Fax No: 传真:
Tel No: 电话:	Tel No: (+86)400 881 1291 电话:
Date: 日期:	Pages: 1 of 页:

Insured: 被保险人:	Date of Birth: 生日:
Policy No: 保单号:	Claim No: 理赔号:
Location: 地址:	Contact No: 联系电话:

To be completed by treating physician 请经治医生填写下表

Treating Physician: 经治医生:	Referring Doctor: 咨询医生
Tel No: 电话:	Tel No: 电话:
Fax No: 传真:	Fax No: 传真:
E-mail: 电子邮件:	E-mail: 电子邮件:
Admitting Hospital: 医院:	Admission Date: 住院日期:
Medical Facility: 医疗机构:	Discharge Date: 出院日期:
Tel No: 电话:	Contact Person: 电话:
Fax No: 传真:	

To be completed by treating physician 请经治医生填写下表

Condition requiring Treatment(Please advise if a chronic condition):_____
需要治疗的疾病(如果是慢性病请如实告知):
Underlying Cause: _____
根本病因:
First Consultation date: ___/___/___ Symptoms apparent from ___/___/___
首诊日期: 初次发现症状时间:
Has this or any similar condition existed previously? □ No □ Yes (if Yes please attach details)
既往是否有这种疾病或出现过相似的症状?
Proposed Treatment / Procedure _____
治疗方案/计划
Medication currently taken _____
目前的药物治疗
Admit as: In-patient / Day patient / Out-patient
病人以何种方式在医院治疗: 住院病人 日间病人 门诊病人

Proposed admission date: ___/___/___ 建议住院日期:	Estimated length of stay: _____ 预计住院时间:

Cost Estimated (to be completed by all relevant parties)费用概算(请个相关部门填写)

Surgeons fee_____ Ward Round Fee_____ per day__ Anaesthetists Fee _____
手术费工 查房费 每天 麻醉费

Room Rate_____ Class of Room _____
床位费 房间类别

Package Cost _____ Other Fee _____
费用总计 其它费用

Hospital Charges (approx) _____ Prompt Payment Discount _____
住院费工 按时付款的折扣

Doctor Signature / Hospital Authority_____ Date ___/___/___
医生签名 / 医院盖章 日期

Please return this form along with full medical reports/ any laboratory test results held in respect of the patient.

Fax: +86 (21) 6326 8525 Email: HTChinaServices@aetna.com
请将病人所有的检查报告和实验室检查结果的资料发送至传真+86 (21) 6326 8525 邮件: HTChinaServices@aetna.com