太平财产保险有限公司
TAIPING GENERAL INSURANCE CO., LTD.

Pre-Authorization Request
事先授权表

Mail Forms To:
邮寄到:
GBG China – ICS GBG 中国
Suite 3401, 707 Zhangyang Road,
Shanghai, 200120 P.R. China
中国上海张杨路707号生命人寿大厦3401室
邮编 200120
Hotline 热线电话: 400 880 8820
Fax传真: +86 21 5835 3368
www.gbg.com

COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS AUTHORIZATION REQUEST

If not a medical emergency as defined by your policy contract, you must wait until you have a written authorization from GBG Assist before proceeding with any procedure requiring pre-authorization. Please see your policy for a list of those procedures, or visit **www.gbg.com**. Otherwise, penalty co-pay will apply to your claims, and the provider may decline to direct bill us.

申请事先授权,以下空格务必填写完整。若为合同条款定义的非急诊且需要事先授权的治疗,则需在收到 GBG Assist 授权担保函后才可进行。您可以参照条款合同或在我们的网站 **www.gbg.com** 上查找到需要事先授权的治疗列表。否则被保人需要支付相应的处罚性自付额，并且网络直付医院可能会拒绝与我们做直付，而需要您做事后理赔。

A. Patient infromation– please write legibly 病人信息

Name (Last, First, MI) 姓名:	Alias 别名:
Date of Birth (MM/DD/YY) 出生日期（月/日/年）:	Policy ID Number 保险号码:
Contact Email 邮箱:	Phone Number 联系电话:
Diagnosis, Symptom, or Complaint (medical necessity for requested procedure): 医疗诊断，症状或主诉（申请的必要治疗）	
Is the patient having surgery: ☐ Yes 是 ☐ No 否 是为病人申请手术吗？	
Is the patient being admitted to the hospital overnight: ☐ Yes 是 ☐ No 否 If yes, expected number of days / duration: 是为病人申请住院治疗吗？（如果“是”请写明估计住院天数）	
Procedure or treatment name 申请治疗项目的名称:	
Expected date of surgery or inpatient admission (MM/DD/YY): 预计手术治疗或住院日期（月/日/年）	
Anticipated type of delivery (for maternity admissions only): ☐ Vaginal 顺产 ☐ Cesarean Section 剖腹产 预计分娩方式（仅因分娩住院填写）	
Estimated cost 估计费用:	Currency 货币:
Hospital/Facility: 医院/医疗机构名称	Physician/Surgeon: 内科/外科医生姓名
Hospital location: 医院地址	Tax ID Number (USA Hospitals Only): 税号（仅美国医院）
First date injury, illness, or accident occurred (MM/DD/YY) 受伤，生病，或意外发生的日期（月/日/年）: Describe how accident occurred if applicable 请描述如何发生的详情: First date you ever received treatment this condition (MM/DD/YY) 您曾经因此问题第一次就诊的日期（月/日/年）	
Describe previous treatment(s) received for this condition, if any, including dates (ex. medicines, consult, surgery, hospitalizations): 请描述您曾因此问题而接受的任何治疗，例如药物、病史、手术、住院治疗详情和日期	

B. Physician information 医生信息

Physician/ Surgeon Name: 主治医生/外科医生姓名	Tax ID Number (USA Doctors Only): 税号（仅美国医院）
Address 地址:	
Telephone Number: 电话	Email: 邮箱地址
PLEASE ATTACH ANY AVAILABLE INITIAL EXAM AND/ OR DIAGNOSTIC REPORTS TO SUPPORT THE MEDICAL NECESSITY OF THIS REQUEST. 请附上检查和/或诊断证明的原件以证明此申请治疗的必要性。	

C. Signature 签名

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

任何人明知索赔材料中包含任何不实陈述或虚假信息，不完整或误导性信息的，可能是一种犯罪行为并根据法律得到惩处，并可能受到民事处罚。

Signature 签名 : **Date 递交日期 :**