Global Health Benefits

事前授权申请表
PRE-AUTHORIZATION APPLICATION FORM

SECTION A：患者详情 Patient's Details	
姓名 Name	Cigna 保险会员号 Cigna Membership ID
出生日期 Date of Birth	公司名称 Name of Company
联系方式 Contact Details	性别 Gender

SECTION B：医疗机构详情 Provider Details	
医疗机构名称 Name of Hospital	联系人 Contact Person 联系方式 Contact Details
主诊/手术医生姓名 Name of treating physician /Surgeon 是否为外聘医生 是Yes ☐ 否No ☐ Whether he/she is invited from other hospital	联系方式 Contact Details 外聘医院 From which hospital

备注：如果病人需要被转院治疗，请如实提供下述信息
Remark: If the patient needs to be transferred to other hospital, please provide below details

医疗机构名称 Name of Hospital	联系人 Contact Person 联系方式 Contact Details
主诊/手术医生姓名 Name of treating physician/Surgeon	联系方式 Contact Details

SECTION C：医疗信息 Medical Information	
疾病初诊日期 First consultation date for this condition	该病情症状出现日期 Date the symptoms first occurred
主诉 Chief Complaint	疾病诊断 Diagnosis
既往治疗史 Treatment history	治疗详情 Details of treatment
主要实验室及其他辅助诊断报告 Major diagnostic test reports	是否是急症 Emergency or not Yes ☐ No ☐ 若是急症，请提供相关医学报告 If yes, please provide supportive medical reports
就诊日期 Proposed Admission Date	预计治疗天数 Estimated length of stay
病人就诊/治疗形式 Patient to be admitted/ treated as 住院 Inpatient ☐ 门诊 Outpatient ☐	诊疗医师签字 Signature of Physician

SECTION D : Estimated Cost (to be filled out by all relevant parties)	
手术费 Surgeon Fee _____ 手术助理费 Assistant Surgeon Fee	麻醉费 Anaesthetist's fee
医院费用包括 Hospital Charges including 手术室费 Operation theatre _____ 药费及敷料费 Drugs and dressing _____ 检查费 Investigation fee _____ 其他 Others _____	住院诊疗费（每天） Inpatient Consultation Fee (per day)
	病房费 Room Rate
	总费用约计 Approximate total charges

请通过发送传真（+8621 6086 3197）或以电子邮件方式（pre-auth@cigna.com）发送给我们完整填写的事前授权申请表。
Please return by fax at +8621 6086 3197 or email at pre-auth@cigna.com in respect of the patient.

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