MSH CHINA

Non-Direct Billing Claim Form - Part A Patient Information

非直付理赔申请书 – A 部分 就诊人信息

For a claim to be valid, the following two pages (Part A and B) must be completed and submitted to MSH CHINA ENTERPRISE SERVICES CO., LTD. (hereinafter "Service Center") which is the appointed Service Provider appointed by your insurance company within 180 days after the date of service.

为确保有效理赔，A与B两部分内容必须填写完整，并在从治疗之日后的180天之内向为您承保的保险公司指定的医疗保险服务机构万欣和（上海）企业服务有限公司（以下简称“服务中心”）提出理赔申请。

Patient Information 就诊人信息	
Member ID 会员号:	DOB 生日: MM月/ DD日/ YY年
Name 姓名:	Gender 性别:
Nationality 国籍:	ID/Passport No. 身份证/护照号码:
Tel. 电话:	Email 电子邮箱:
Address 地址:	
Ref.# (refer to insurance card):	
Policy Number 保单号:	

Primary Insured Information 主被保险人信息 **If claim is for the Primary Insured, please do not need to fill out the Primary Insured Information.** **注：如果理赔申请人是主被保险人，则无需填写主被保险人信息。**	
Name 姓名:	DOB 生日: MM月/ DD日/ YY年
Gender 性别:	ID/Passport No. 身份证/护照号码:
Tel. 电话:	Email 电子邮箱:
Address 地址:	

1. Describe Injury or Illness 受伤或疾病描述	
Diagnosis or Chief Complaint 诊断或主诉:	
On what date (month/year) did you first notice the conditions or date of the symptoms appear? (Please describe the symptoms)? 请问该疾病第一次发现的时间或者相关症状第一次出现的时间是什么时候？ MM月/ DD日/ YY年	
On what date (day/month/year) did you first seek a doctor's opinion regarding these conditions? 您第一次就诊的时间是在什么时候？	
Are you also covered by another insurance policy？您购买了其他的保险吗？ ☐ Yes 是 ☐ No 否	
Policy # 保单号:	Name of other insurance company 其他保险公司的名称:

2. Payment Information 银行转帐信息 (Please complete clearly, otherwise your non-network payment will be delayed. 请务必清楚填写, 否则您的个人理赔赔付会被延误.)	
☐RMB bank account(Mainland China) 人民币账户	**☐Non-RMB bank account(Out of Mainland China)非人民币账户**
Account # 帐号:	Name on the Account 帐户名:
Name of bank and branch开户银:行:	Swift Code /Routing# /ABA#(For non-RMB account非人民币账户):
Bank address银行地址(For non-RMB account非人民币账户):	
***Please ensure the name on the invoice is the same as that on your ID/passport. 请务必保证您发票上的姓名与身份证或护照上姓名保持一致。**	

The above answers are true and correct to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to the Service Center including copies of records, concerning advice, care or treatment provided to me or my dependent as is required to properly pay all benefits, if any, due me, or my dependent for this claim. If this claim is direct billed, I acknowledge that I am responsible for any fees that my insurance policy does not cover. A photocopy of this authorization shall be considered as effective and valid as the original.

尽我所知所信，以上回答是正确属实的。如果此理赔需要，为使我、我的附属被保险人完全得到应偿付的所有保险金，我授权任何医生、医疗机构、药剂师、保险公司、雇主、工会或协会将我、我的附属被保险人就医治疗、接受护理的相关病历、病史等资料信息（包括复印件）提供给服务中心。此理赔如属于直接付费，我愿意承担此保险所不承担的所有费用。此授权的复印件与原件具有同等效力。

Primary Insured's Signature: **主被保险人签字**	**Dependent's Signature:** **附属被保险人签字:**
Date 日期: MM月/ DD日/ YY年	

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Claim Form - Part B Medical Information

理赔申请书 – B 部分 医疗信息

Please note: A photocopy of the medical record(s) from the outpatient visit(s) may replace Part B of this Claim Form. Please submit discharge summary if it is an inpatient claim.

备注：门诊病历复印件可取代理赔申请书B面信息。住院理赔请提供出院小结。

3. Medical Information - To be Completed by the Treating Physician 医疗信息 – 由治疗医师填写	
Doctor's Name 医师姓名:	Phone # 电话:
Hospital's Name 医院名称:	Address 地址:

Chief Complaint 主诉:

Physical Examination 体格检查:
Lab Tests and Exams 化验和检查有:
Lab tests' Results 实验室化验结果:
Exam Results 检查结果:

Diagnosis/Impression 诊断/印象:

Details of treatment provided 治疗措施:

Please state name of drug(s) and dosage(s), otherwise your claim payment will be delayed. 请提供药品的名称和剂量，否则您的理赔赔付将会被延迟:

Treatment is related to (Please check box if related to one of the following items) 本次治疗是否与以下相关（如是，请标出）:

☐ Maternity 产检或生产
☐ Therapy 理疗
☐ Acupuncture 针灸
☐ Checkup 体检
☐ Immunization 注射疫苗
☐ Dental 牙科
☐ Vision 视力
☐ Others 其他

Date of Service 治疗日期	**Description of Medical Procedure 医疗费用明细**	**Charges 收费**
	Consultation fee(s) 诊疗费	
	Drug fee(s) 药费	
	Lab test fee(s) 实验室化验费	
	Exam fee(s) 检查费	
	Acupuncture fee(s)针灸费	
	Therapy fee(s) 理疗费	
	Others 其他	
	Total 总计	

Signature of Treating Physician 治疗医生签名:

Print Name and Title 姓名和职位: Date 日期: MM月/ DD日/ YY年

*****Please send this completed Claim Form, along with the photocopy of the patient's valid picture ID card / Passport & insurance card, original Invoice(s)/Receipt(s), photocopy of your medical record, prescription (if any) and discharge summary (for inpatient claims), to the Service Center. 请将此填写完整的理赔申请书及病人带照片的有效身份证件/护照和保险卡的复印件、原始发票、病历报告、处方(如果有)、出院小结（住院治疗）的复印件一起寄至服务中心。

Submit Claims to Service Center • 理赔资料寄送至服务中心
5F, Building 9, Lujiazui Software Park, Lane 91, E Shan Road, Pudong, Shanghai, P.R.C 200127
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Tel: +86 21 6187 0330 • Fax: +86 21 6160 0208 • Email: claims@mshasia.com