Hong Kong Claim Form
香港理賠申請表格

To be used for out-of-network claims under the Cigna*Links*®*… Hong Kong programme.*
供 Cigna*Links*®*--香港計劃於非醫療網絡的索償使用。*

Section A. Important Information: Please Read
甲部.重要資料：務請細閱

Please complete and sign this claim form, and submit it along with itemised bills and receipts detailing the services rendered.
請填妥及簽署本理賠申請表格，並連同詳細列舉所提供服務的賬單及收據一併呈交。

Payment will be made to the employee only.
賠款只向僱員作出。

Send your completed form, itemised bills, and receipts:
請透過以下方式提交已填妥的表格、詳細列舉的賬單及收據：
By fax to (852) 2851-2845
傳真：(852) 2851-2845
By mail to QHMS Claims Department,
Quality HealthCare Medical Services Limited
3/F, Skyline Tower, 39 Wang Kwong Road
Kowloon Bay, Kowloon
郵寄： 香港九龍宏光道 39 號宏天廣場 3 樓
卓健醫療服務有限公司
卓健理賠部

Questions? Please contact QHMS
By *phone* at (852) 8205-8205
By *email* at cignalinks@qhms.com

如有任何疑問，請按以下方式與卓健聯絡
電話：(852) 8205-8205
電郵：cignalinks@qhms.com

Section B. Employee and Patient Information (Please complete a separate claim form for each family member.)
乙部.僱員及病人資料（請就每名家庭成員填寫獨立的理賠申請表格。）

1. Employee's Name
僱員姓名 _____

2. Patient's Name
病人姓名 _____

3. Employee's Date of Birth
僱員出生日期 _____

4. Patient's Date of Birth
病人出生日期 _____

5. Daytime Telephone
日間電話 _____

6. Email Address
電郵地址 _____

7. Membership No.
醫療咭編號 _____

8. Please indicate if you carry other health or travel insurance from which you may receive full or partial reimbursement.
請列出閣下可能獲全數或部分賠償的其他醫療或旅遊保險（如有）。
Name of Insurance Company
保險公司名稱 _____
Covered Amount (please provide supporting documents with breakdown of the covered amount)
從其他醫療或旅遊保險所獲得的賠償金額（請提供相關文件及詳細列舉獲得的賠償項目）
_____

Section C. Payment Details

丙部.賠款詳情

1. List of expenses for which reimbursement is claimed, the date of service, and the amount.

請列出索償清單、服務日期及金額。

Diagnosis診斷 *(reason for treatment)* *（治療原因）*	Date of Service 服務日期 *(earliest if multiple)* *(請以最早日期開始排列）*	Amount 金額 *(HK Dollars)* *（港元）*

2. Select payment method Cheque Bank Transfer

選擇賠款方法 **支票** ☐ **銀行轉賬** ☐

** Cheques will be issued to the policy holder (staff member) and mailed to your primary mailing address.*

**支票抬頭將為保單持有人（僱員)並寄予閣下的第一郵寄地址。*

Please contact QHMS to make sure that this address is current if you have recently relocated.

請聯絡卓健確保此地址為最新地址（如最近搬遷）。

3. If payment is to be sent to your bank account, please complete the following.

如以銀行轉賬方式收取賠款，請填妥以下各項：

Name of Account Holder *(must be exact)*

戶口持有人姓名*（必須準確無誤）*_____

Bank Account No. Bank Name

銀行戶口號碼_____ **銀行名稱**_____

Sort/Swift/ABA – Routing Code

路由編碼_____

Bank Branch Address

銀行分行地址_____

Currency of Account†

戶口貨幣†_____

† *Please note: Reimbursement for claims made on this form will be in Hong Kong Dollars only.*

†*請注意：就本表格所提出索償的理賠金額將只以港元支付。*

Fraud Notice:

詐騙須知：

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing false, incomplete, or misleading information commits a fraudulent insurance act, which is a crime.

任何人士如在知情情況下企圖傷害、詐騙或欺詐任何保險公司、呈交載有失實、不完整或誤導資料的索償單即屬違法，並構成保險欺詐行為。

Patient's Signature and Release *(parent or guardian, if claim is for a minor)*:

病人簽署、聲明及授權*（如受保人未成年，須由父母或監護人簽署）*：

I certify that the information supplied is true and correct. I authorise the release of all records or other information which may be necessary to determine benefits payable. The information provided on this form may be used and disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing of this claim and performing health plan administration.

本人謹此證明所提供的資料乃屬真確。本人授權發放所有為釐定應付利益而必要的記錄或其他資料。就處理本索償及進行醫療保健行政事宜而言，本表格中所提供的資料可能用作及披露予其他人士或實體，包括計劃保薦人。

Patient's Signature病人簽署_____ Date日期_____