MSH CHINA

Claim Form - Part A Patient Information

理赔申请书 – A 部分 病人信息

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. / SHANGHAI TAI KAI BUSINESS MANAGEMENT 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，您必须完整填写以下内容（A与B两部分），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上海万欣和企业服务有限公司/上海泰凯企业管理有限公司（以下简称“服务中心”）提出理赔申请。

Pre-authorization is required for certain treatments. Failure to obtain pre-authorization will result in certain co-payment.

某些治疗需事先授权。未经事先授权将导致一定比例的自付额。

1. Who is this Claim for? 理赔申请人: ☐ Primary Insured 主被保险人 ☐ Dependent 附属被保险人

NOTE: If claim is for the Primary Insured, please do not fill out Dependent Information.

注：如果理赔申请人是主被保险人，则无需填写附属被保险人信息。

Primary Insured Information 主被保险人信息	**Dependent Information 附属被保险人信息**
English Name 英文姓名:	English Name 英文姓名:
Chinese Name 中文姓名:	Chinese Name 中文姓名:
Member ID 会员号:	☐ Male 男 ☐ Female 女
☐ Male 男 ☐ Female 女	Relationship with Primary Insured 与主被保险人关系:
DOB 生日: MM月/ DD日/ YY年	☐ Spouse 配偶 ☐ Child 子女
Mailing Address 邮寄地址:	DOB 生日: MM月/ DD日/ YY年
	Mailing Address 邮寄地址:
Tel. 电话: Fax 传真:	Tel. 电话: Fax 传真:
Email 电子邮箱:	Email 电子邮箱:

Insurance Company:
保险公司:

Policy # (refer to insurance card):
保单号（见保险卡）:

Ref.# (refer to insurance card):
代码（见保险卡）:

Name of Policyholder (Group policy only):
投保人名称（仅限于团体保险）:

2. Describe Injury or Illness 受伤或疾病描述

Is this the first time you sought treatment for this Injury/Illness? 受伤/疾病是第一次就诊吗? ☐ Yes 是 ☐ No 否

If No, give the date you first consulted a physician for the same Illness/Injury 如不是，请写出第一次就诊日期:

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:

3. Payment Information 银行转帐信息 (Please complete clearly 请务必清楚填写)

RMB Bank Account Information (Bank account must be located in Mainland China) 人民币帐户(仅限中国大陆地区):

Account # 帐号: Name on the Account 帐户名:

Name of bank and branch开户银行: Province 省 City 市 Bank 银行

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: **Dependent's Signature:**

主被保险人签字 **附属被保险人签字:**

Date 日期: MM月/ DD日/ YY年

MSH CHINA

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 visit(s) may replace Part B of this Claim Form.
备注：病历复印件可取代理赔申请书B面信息。

4. Medical Information - To be Completed by the Treating Physician 医疗信息 – 由主诊医师填写

Doctor's Name 医师姓名: Phone # 电话:

Hospital's Name 医院名称: Address 地址:

Patient's Chief Complaint 病人主诉:

Physical Examination 体格检查:
Necessary Lab Tests 病人需要做的实验室检查有:
Lab tests' Results 实验室检查结果:

Diagnosis/Impression 诊断/印像:

Details of treatment provided 治疗措施:

Please state name of drug(s) and dosage(s) 药品的名称和剂量:

Will Illness/Injury require follow up treatment? If so, please give details. 受伤/疾病需要后续治疗吗？如果需要，请说明详情:

When did patient seek treatment for this condition for the first time? 病人第一次就诊此疾病的时间？（第一次确诊的时间?）
Date日期: MM月/ DD日/ YY年

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 产前检查或生育
☐ Physical Therapy 物理治疗
☐ Chinese Traditional Medicine 中医
☐ Full Body Checkup 全身体检
☐ Immunization or Wellness Checkup 注射疫苗或单项体检
☐ Dental 牙科
☐ Vision 视力

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) 实验室检查费	
	Treatment fee(s) 治疗费	
	Others 其他	

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 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
East Unit, 5th Floor, North Tower, Building 9, Lujiazui Software Park, No. 20, Lane 91, E Shan Road,
Pudong, Shanghai, P.R.C 200127
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