



Quality HealthCare Medical Services Limited (QHMS) is a service provider appointed by CIGNA to provide services for CIGNA HealthFirst Medical Series, including the administration of claims. Please call the QHMS managed CIGNA HealthFirst Hotlines for any claim related enquiry. Tel: (852) 8203 2202 Fax: (852) 2534 0223  
Please mail your completed claim form and related original medical receipts to QHMS Claims Department (Medical Affairs Team), Quality HealthCare Medical Services Limited, 4/F 303 Des Voeux Road Central, Sheung Wan, Hong Kong.

信諾委任卓健醫療服務有限公司(卓健)為信諾醫療保系列之服務商,其服務包括處理索償事務。如有關任何索償事項查詢,請致電卓健提供之信諾醫療保專線。電話:(852) 8203 2202 傳真:(852) 2534 0223 請郵寄已填妥之索償表格及有關之醫療收據正本至香港上環德輔道303號4樓卓健醫療服務有限公司卓健醫療理賠部(MAT)。

This form must be completed in full for us to process the application for the Guarantee of Payment Letter. 您必須填妥此表格所需的全部資料,以便辦理「住院付款保證信」之申請。

**Part A - To Be Completed By Policyholder 第一部份 — 由保單持有人填寫**

Name of Policyholder 保單持有人姓名 \_\_\_\_\_ Date of Birth 出生日期 \_\_\_\_\_ (年/月/日) (YY/MM/DD)  
Policy No. 保單編號 \_\_\_\_\_ Contact No. (Tel / Fax) 聯絡號碼(電話/傳真) \_\_\_\_\_

**Declaration & Authorization 聲明及授權**

(To be signed by insured. If insured is below 18 years old, please sign by Policyholder 請由受保人簽署,如受保人未滿18歲,則由保單持有人簽署)

I hereby declare all the statements to all questions above, whether or not written by my own hand are to the best of my knowledge and belief complete and true. I agree that any concealment or misstatement as regards to amount or otherwise, in connection with this claim may result in prosecution and the policy shall become void.

I consent that the personal information collected or held by the Company, whether contained in this application or otherwise obtained, is provided and may be transferred or disclosed to any physician, hospital, pharmacy, insurance company, police station, employer, or other organization, who has records or knowledge of myself or the insured, to release all information regarding medical history - prognosis treatment (including drug and alcohol abuse information), sick leave history, employment history, reason of employment termination, earnings or benefit payable under other insurance coverage within or outside Hong Kong for processing, investigation and claims analysis/assessment.

本人謹此聲明上述一切陳述,不論是否本人親手所寫,均屬正確無訛,並為吾所知所信之全部。本人同意任何蓄意欺騙或隱瞞將構成法律責任並導致保單失效。

本人同意信諾收集或持有本人之個人資料,不論是否由此申請書或其他途徑取得,並可能提供、轉移或披露予任何持有有關於本人或上述受保人記錄或資料之香港或海外醫生、醫院、藥劑師、保險公司、警署、僱主、或其他機構發放有本人或上述投保人之病歷、病情預後、治療、醫假、或在職、離職詳情、或在其他保障下可獲之保障額、索償金等資料,作為處理、調查和索賠分析或評估。

Signature of Insured / Policyholder (if insured is below 18 years old) 受保人/保單持有人簽署(如受保人未滿18歲) \_\_\_\_\_

Date Signed 簽署日期 \_\_\_\_\_

Name of Insured / Policyholder (in block) 受保人/保單持有人姓名(請以正楷書寫) \_\_\_\_\_

HK Identity Card No. of Insured / Policyholder 受保人/保單持有人香港身份證號碼 \_\_\_\_\_

**Shortfall Collection Credit Card Authorization Form 繳付差額費用之信用卡授權書**

If the amount paid by QHMS to the hospital exceeds the eligible claims arising from this hospitalization, this Form authorizes QHMS to collect the shortfall amount from the following credit card account. The credit cardholder should be the Policyholder of this policy.. The shortfall collection notice will be sent to you 5 days prior to the collection.

如卓健直接支付予醫院的費用超出是次住院應付的賠償額,此授權書將授權卓健從以下信用卡帳戶收取此差額。持卡人必須為此保單之持有人。卓健將於收取差額費用5天前郵寄欠付款通知書通知閣下。

Credit Card Authorization Form 信用卡付款授權書 (this section must be completed 此部份必須填寫)

Cardholder's Name 持卡人姓名	HKID Card No. 持卡人香港身份證號碼	Signature of Cardholder (must be the same as that on the Credit Card) 持卡人簽署(須與信用卡上簽名相同)
Credit Card Account No. 信用卡號碼	Credit Card Expiry Date 信用卡到期日 (MM/YY 月/年)	
I hereby authorize and direct Quality HealthCare Medical Services Limited to debit the outstanding shortfall due from my credit card account 本人授權及指示卓健醫療服務有限公司從本人信用卡戶口扣除到期之差額費用		X
Contact no. 聯絡號碼	Date 日期	Date 日期 _____ (年/月/日) (YY/MM/DD)

**Part B - To Be Completed By The Attending Physician / Surgeon 第二部份 — 由主診醫生填寫**

Patient Name 病人姓名 \_\_\_\_\_ HKID Card No. 香港身份證號碼 \_\_\_\_\_ Age 年齡 \_\_\_\_\_ Sex 性別 \_\_\_\_\_ M / F 男 / 女

**Medical History 病歷**

1. Diagnosis / symptoms 診斷 / 病癥

i. Prior to this consultation, did patient first consult you for the related signs and symptoms? And when was the first consultation?

在是次求診日期前,病人有否在台端執業之診所診治有關上述病況之紀錄?如有,病人始自何時求診?

NO 否  YES, the first consultation was since 有,第一次求診日期始自 \_\_\_\_\_ (年/月/日) (YY/MM/DD)

ii. According to the patient, for how long had such symptom(s) persisted before the first consultation?

據病人自述,上述病徵在求診前出現多久? \_\_\_\_\_

2. Consultation date of the first episode 首次診症日期為: \_\_\_\_\_ (年/月/日) (YY/MM/DD)

3. Onset date of the symptoms / condition 發病日期: \_\_\_\_\_ (年/月/日) (YY/MM/DD)

**Hospitalization Details 住院詳情**

Hospital name 醫院名稱 \_\_\_\_\_ Class of bed: Ward / Semi-private / Private / Others: 住房級別 普通病房 / 半私家 / 私家 / 其他: \_\_\_\_\_  
Admission date 入院日期 \_\_\_\_\_ (年/月/日) (YY/MM/DD) Expected Length of Stay 預計住院日數 \_\_\_\_\_ day(s) 日

**Treatment Details 治療詳情**

Surgery / treatment required 建議之手術 / 治療: \_\_\_\_\_ Reason for this hospitalization 住院原因: \_\_\_\_\_  
Lab tests / Imaging / other diagnostic investigation required 建議之化驗 / 影像檢查 / 其他診斷性檢查: \_\_\_\_\_ Anaesthesia 麻醉: G.A.全身麻醉  L.A.局部麻醉

If you have recommended the patient for specialist's opinion (other than attending Physician), please give specialist name and nature of treatment provided: 如有轉介予專科診治,請提供專科醫生之姓名及治療詳情: \_\_\_\_\_

**Physician's Information 醫生資料**

Physician's name 醫生姓名 \_\_\_\_\_ Signature of Physician and Chop 醫生簽署及印章 \_\_\_\_\_  
Contact no. 聯絡號碼 \_\_\_\_\_ (Tel 電話) \_\_\_\_\_ (Fax 傳真) \_\_\_\_\_ Date 日期 \_\_\_\_\_

## How to apply Guarantee of Payment Letter (GOP)\* for your hospital confinement ?

若需要住院，如何申請住院付款保證信\*？

Call CIGNA HealthFirst Hotline for Pre-admission arrangement  
(852) 8203 2202

致電信諾醫療保專線 (852) 8203 2202

Complete the Hospital Pre-admission Form and send to QHMS  
by fax on (852) 2534 0223 / post / in person #

填妥住院審批申請書，然後傳真至卓健 (852) 2534 0223 / 郵遞 / 親身交回卓健 #

QHMS will send a Guarantee of Payment (GOP) Letter to  
attending hospital

醫院將會收取卓健發出的住院付款保證信

Upon admission, present the CIGNA HealthFirst Medical Card and HKID Card  
to hospital for registration

入院時，向醫院出示信諾醫療保醫療卡及身份證以作登記

You will receive the Claim Settlement Advice (with shortfall details if applicable) 10  
working days^ after QHMS receiving full documentation from hospital.

由收妥醫院提交齊備文件後，卓健將於10個工作天^內通知保單持有人有關的賠償詳情及繳付有關之差額費用(如適用)。

\* Eligibility to this benefit is subject to the terms and conditions of the relevant policy provisions and the acceptance of the "Guarantee of Payment Letter" by the hospitals

此保障須受有關保單條款及細則約束及有關醫院是否接受「付款保證信」。

# You will be required to provide treatment information and authorize QHMS to collect shortfall of medical expenses, if any, from your credit card account

您須提供治療資料及授權卓健從您的信用卡帳戶收取醫療費用的差額 (如有)

^ The actual date of claims notification depends on the submission of required documents from hospital

卓健通知保單持有人有關賠償的所需日數會因應醫院遞交賠償所需文件而有所不同