中高端医疗险理赔申请书（非直付）
MEDICAL BENEFITS CLAIM FORM(NON DB)

(CF004)

申请人填写部分 To BE COMPLETED BY PATIENT OR PRIMARY INSURED

保单号：
POLICY No.

就诊人信息 PATIENT INFORMATION

1.姓名 PATIENT'S NAME	2.卡号 CARD No.	3.性别 SEX	4. 出生日期 DATE of BIRTH
		☐ 男 M ☐ 女 F	YYYY / MM / DD
5.证件类型 ID TYPE ☐ 身份证ID ☐ 护照 PASSPORT ☐ 其他OTHERS:_____	6. 证件号码 ID No.	7.证件有效期 ID Validity Period	8.国籍 Nationality
9.联系电话 TEL NO	10.电邮 EMAIL	11.是投保人的 Relationship to Policyholder	

12.就诊人地址（街道，号码） PATIENT'S ADDRESS (Street, NO.)	区(District)	城市(City)	省市(Province)	邮编(Zip Code)

13.是否受雇？ IS PATIENT EMPLOYED?	14. 单位名称和地址 NAME & ADDRESS OF EMPLOYER
☐ 是 YES ☐ 否 NO	

15. 理赔申请与意外有关？ IS CLAIM RELATED TO AN ACCIDENT?	16. 意外发生日期 DATE OF ACCIDENT	17. 意外如何发生 DESCRIPTION OF HOW ACCIDENT OCCURRED
☐ 是 YES ☐ 否 NO	YYYY / MM / DD	

18.是否有其他医疗保险？ DOES THE PATIENT HAVE OTHER MEDICAL INSURANCE COVERAGE?	19.其他保险机构名称及保单号 NAME OF OTHER MEDICAL INSURANCE COMPANY AND POLICY NUMBER
☐ 是 YES ☐ 否 NO	

主被保险人信息（仅当主被保险人与病人非同一人时填写）
PRIMARY INSURED INFORMATION (Complete on if primary insured is other than patient)

20.主被保险人姓名 NAME OF PRIMARY INSURED	21.证件类型 ID TYPE ☐ 身份证ID ☐ 护照 PASSPORT ☐ 其他OTHERS:_____	22. 证件号码 ID No.	23.证件有效期 ID Validity Period
24.国籍 Nationality	25.联系电话 TEL NO	26.是投保人的 Relationship to Policyholder	

27.地址（街道，号码）ADDRESS (Street, NO.)	区(District)	城市(City)	省市(Province)	邮编(Zip Code)

28.电邮 EMAIL	29. 与就诊人关系RELATIONSHIP TO PATIENT	30. 单位名称EMPLOYER'S NAME

赔款指示PAYMENT INSTRUCTIONS

31. (请务必清楚填写，否则您的个人理赔赔付可能延误。 Please complete clearly, otherwise your payment will be delayed.)

帐号ACCOUNT #	帐户名 NAME	开户行BANK NAME

非人民币账户For non-RMB account

Swift code/Routing #/ABA#:_____ Bank address:_____

授权保险公司留存，供后续理赔给付使用？
Authorize the insurance company to record the bank details for future claim payments? ☐ *是 Yes* ☐ *否 No*

(注：支付给非病人本人或其监护人的，须提供授权。 Authorization is required in case of payment to a person other than the patient or the patient's legal guardian.)

由医生或医疗提供方填写 To BE COMPLETED BY PHYSICIAN OR SUPPLIER

（门诊病历复印件可替代，住院请附出院小结。A photocopy of the medical record(s) from the outpatient visit(s) may replace this part. Please submit discharge summary if it is an inpatient claim.）

医疗信息MEDICAL INFORMATION

32.疾病（首次症状）或伤害发生日期 DATE OF ILLNESS (FIRST SYMPTION) OR INJURY (ACCIDENT) YYYY | MM | DD	33.首次就诊日期DATE FIRST CONSULTED YOU FOR THIS CONDITION YYYY | MM | DD
34.如病人曾有类似症状或伤害，请说明日期 IF PATIENT HAS HAD SIMILAR ILLNESS OR INJURY, GIVE DATES YYYY | MM | DD	35.请提供病情或伤害的诊断结论PLEASE GIVE YOUR DIAGNOSIS OF THE ILLNESS OR INJURY

36.日期 DATE of SERVICE (YYYY/MM/DD)	医疗机构 PROVIDER	病情描述或诊断 ILLNESS OR DIAGNOSIS	类型 TYPE OF SERVICE	费用金额 AMOUNT
			☐ 门诊 OP ☐ 住院 IP	
			☐ 门诊 OP ☐ 住院 IP	
			☐ 门诊 OP ☐ 住院 IP	
			☐ 门诊 OP ☐ 住院 IP	
			☐ 门诊 OP ☐ 住院 IP	

（如行数不够可用改格式添加副页填写。 If this space is not sufficient, you may add more pages to this form using the same format.）

X 治疗医生签名 Signature of Treating Physician:_____ **X**姓名和职位Print Name and Title:_____ **X**日期Date: ——月MM/——日DD/—— 年Y

声明与授权 DECLARATION & AUTHORIZATION

1、本人声明以上陈述与回答全部属实及详尽。I hereby declare that the above information is true & correct to the best of my knowledge.

2、本人授权任何医疗机构、社保或农保机构、保险公司、公安机关、疾病防治中心等有关机构及一切熟悉被保险人身体健康状况、相关事故的人士，均可将有关被保险人资料向复星联合健康保险股份有限公司（以下简称“贵公司”）或通过中国保险行业协会、中国银行保险信息技术管理有限公司（以下简称“中国银保信”）、保险交易所及其合作伙伴等贵公司所委托的合作机构如实提供。本人愿意承担由此产生的一切法律后果。I authorize all relevant institutions including establishments, social insurance or rural cooperative agencies, insurance companies, public security organs and centers for disease control and prevention and all persons familiar with the physical health situation of the insured and relevant event to provide relevant information and materials of the insured truthfully to Fosun United Health Insurance Co., Ltd. (your Company), or through cooperative institutions entrusted by your Company including the Insurance Association of China, China Banking and Insurance Information Technology Co., Ltd. (CBIT), insurance exchange and their partners. I am willing to undertake all the legal consequences arising therefrom.

3. 本人同意贵公司向中国银保信报送本人的全部保单信息和理赔信息，并通过医疗机构、中国银保信及知悉本人信息的其他机构查询与本人有关的承保、理赔、医疗等信息。I agree that your Company shall report all of my insurance policy and claim information to CBIT, and inquire about underwriting, claim and medical information relating to myself through medical establishments, CBIT and other institutions aware of my personal informaiton.

4. 本人同意贵公司、中国银保信基于为本人或保险公司提供服务的需要，可对上述信息进行必要的使用及与相关机构进行信息共享，但均应严格履行保密义务。I agree that your Company, CBIT can make necessary use of the information above and share such information with relevant institutions based on the need of your Company and CBIT to provide services for me or the insurance company, but such information must be kept in strict confidence.

5、本人已核对提供的银行账户，因该账户信息错误导致转帐失败或错误转帐，本人将承担所有责任。I have checked the bank account, and I should bear all responsibility for any failed and wrong transfer due to incorrect account information.

6、本人同意：从本次理赔的合理保险金给付中，扣除我尚未偿还的不属于保险责任范围但复星联合健康保险股份有限公司已为本人向医疗机构垫付的医疗费用。I agree that the medical expenses that your company has already paid to the medical institution and which are not covered by my insurance policy will be deducted

X 申请人签字: **APPLICANT SIGNATURE** _____ **X 日期:** **DATE (YYYY/MM/DD)**_____

*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（若有）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）的复印件一起邮寄。

Please send this completed Claim Form, along with the photocopy of the patient's valid picture ID card / Passport & insurance card (if any), originalInvoice(s)/Receipt(s), photocopy of your medical record, prescription (if any) and discharge summary (for inpatient claims), to the Service Center.

理赔寄至Submit Claims to Service Center

上海市虹口区海伦路440号金融街（海伦）中心 1901室 (200086) 高端医疗理赔受理（收），021-61921777

Unit 1901, financial street hailun center, No. 440, Hai Lun Rd., Hongkou District, Shanghai 200086, High helath insurance claim reception, 021-61921777

24小时客户服务/保险咨询/理赔查询：4006-11-7777 claims@fosun-uhi.com Service/ Inquiry/Claims: 4006-11-7777 claims@fosun-uhi.com