复星联合健康保险股份有限公司

Fosun United Health Insurance Co., Ltd.

LP01-理赔申请书

直付理赔申请书（2023 版）

Direct Billing Claim Form（2023）

申请人填写部分 TO BE COMPLETED BY PATIENT OR APPLICANT

就诊人信息 PATIENT INFORMATION

就诊人与投保人关系 Relationship Between the Patient and the Policyholder: ☐本人 Principal ☐父母 Parents ☐配偶 Spouse ☐子女 Children ☐其他关系 Others:

保单号 Policy No.:	姓名 Name:	性别 Gender: ☐男 Male ☐女 Female
生日 Date of Birth: 月 MM 日 DD 年 YYYY	国籍 Nationality:	职业 Occupation:
证件类型 Type of ID document: ☐中国居民身份证 Chinese ID Card ☐护照 Passport ☐其他 Others:	证件号码 Number of ID document:	
	证件有效期 Period of Validity: 月 MM 日 DD 年 YYYY 至 to 月 MM 日 DD 年 YYYY ☐长期有效 Permanent	
	电话 Tel.:	电子邮箱 Email:
	常住地址 Permanent Address：	

申请人信息 APPLICANT INFORMATION

申请与就诊人关系 Relationship Between the Applicant and the Patient: ☐本人 Principal（无需填写下列信息 No need to fill in the following information）
☐父母 Parents ☐配偶 Spouse ☐子女 Children ☐其他关系 Others:_____（非本人请填写下列信息 Please fill in the following information）

证件类型 Type of ID document: ☐中国居民身份证 Chinese ID Card ☐护照 Passport ☐其他 Others:	姓名 Name:	性别 Gender: ☐男 Male ☐女 Female
	证件号码 Number of ID document:	
	证件有效期 Period of Validity: 月 MM 日 DD 年 YYYY 至 to 月 MM 日 DD 年 YYYY ☐长期有效 Permanent	
	电话 Tel.:	电子邮箱 Email:

提示：直付服务仅为我司为您垫付本次就诊发生的保险责任范围内的医疗费用，对于不属于保险责任范围内的医疗费用、超出相应费用限额的医疗费用、应当由被保险人按比例自付的医疗费用等情况，医院将直接与您结算。若我司已经代为支付给医院，我们将会联系您并且请您及时退还这笔就诊费用。

Note: Direct billing is limited to the covered medical expenses that we have paid on your behalf for this service. You will have to refund us for any medical expenses outside of the insurance coverage, medical expenses in excess of relevant benefit limits, medical expenses that have a co-payment for the insured…etc. In such cases, the hospital will charge you directly. If we have already paid on your behalf, we will ask for reimbursement from you.

反保险欺诈提示 Insurance Anti-Fraud Prompt

诚信是保险合同基本的原则，涉嫌保险欺诈将承担以下责任。Integrity is the fundamental principle of an insurance contract. If engaging in insurance fraud, one will undertake the following legal liabilities:

【刑事责任 Criminal liabilities】进行保险诈骗犯罪活动，可能会受到拘役、有期徒刑，并处罚金或者没收财产的刑事处罚。保险事故的鉴定人、证明人故意提供虚假的证明文件，为他人诈骗提供条件的，以保险诈骗罪的共犯论处。Whoever commits insurance fraud is subject to criminal liability and may be sentenced to criminal detention or fixed-term imprisonment, and shall also be fined or subject to confiscation of property. The appraiser of the insurance accident who intentionally provides false documents for another person to defraud shall be regarded as an accomplice in the crime of insurance fraud and punished as such.

【行政责任 Administrative liabilities】进行保险诈骗活动，尚不构成犯罪的，可能会受到 15 日以下拘留、5000 元以下罚款的行政处罚；保险事故的鉴定人、证明人故意提供虚假的证明文件，为他人诈骗提供条件的，也会受到相应的行政处罚。 If the insurance fraud activities can't constitute a crime, administrative penalties of 15 days of administrative detention or a fine of less than RMB5,000 may still apply. The appraiser of the insurance accident who intentionally provides false documents for another person to defraud shall be regarded as an accomplice and is subject to the corresponding administrative penalties.

【民事责任 Civil liabilities】故意或因重大过失未履行如实告知义务，保险公司不承担赔偿或给付保险金的责任。If one fails to fulfill the obligation of disclosure on purpose or due to gross negligence or there are other insurance fraud activities, the insurer reserve the right to deny coverage of the related costs.

声明及授权 Authorization and Declaration

1. 本人声明上述填写内容，及本人提供的一切资料均完全属实，并无虚假或重大遗漏，且已阅读并知晓《反保险欺诈提示》，如有虚假或隐瞒情况，贵公司有权拒付保险赔偿金并依法追究法律责任。I hereby declare the information and all materials submitted by me are true and correct without false statements and gross omission. I have read and acknowledged the Insurance Anti-Fraud Prompt. Your company is entitled to refuse to pay the insurance reimbursement and pursue the corresponding legal liabilities in case of false statement or concealment.

2. 本人同意并授权贵公司及贵公司所委托的合作机构向被保险人接受过治疗或住院或具有被保险人健康情况记录的任何内外科医生、医院、诊所、公安、保险公司或任何组织检索、调阅、摘录、复印或以其他方式收集、获取和使用该事故、意外或疾病之细节、被保险人健康情况、过往的病历、医嘱，以及任何住院、治疗、病历详细资料以用于为其提供保险理赔以及其他保险服务。本人愿意承担由此产生的一切法律后果。此授权书的复印件与正本具同等效力。I agree and authorize your company and the cooperative institutions appointed by your company to make a payment to any physician, surgeon or hospital where the Insured has been treated or hospitalized or has a record of the health condition of the Insured To retrieve, access, extract, copy or otherwise collect, obtain and use details of the accident, accident or illness, the insured's state of health, past medical records, medical orders, and any hospitalization, treatment, medical record details for the purpose of providing insurance claims and other insurance services. I am willing to bear all the legal consequences arising therefrom. A photocopy of this authorization letter shall have the same effect as the original.

3. 本人同意在法律允许的范围内，将本人的保单信息、理赔信息，贵公司根据本保险合同之需要而查询和收集的相关信息以及履行本保险合同可能涉及的医疗信息提供给中国银行保险信息技术管理有限公司（简称“中国银保信”），进行信息管理及合理利用。I agree that within the scope permitted by law, I will provide my policy information, claim information, relevant information that your company will inquire and collect in accordance with the needs of this insurance contract and medical information that may be involved in the performance of this insurance contract to China Banking and Insurance Information Technology Management Co., Ltd. for information management and reasonable use.

4. 贵公司及委托的第三方对上述信息负有保密义务。本条款自本单证签署时生效，具有独立法律效力，不受合同成立与否及效力状态变化的影响。Your company and the third party entrusted to keep the above information confidential. This clause shall come into force upon the signing of this document and shall have independent legal effect, and shall not be affected by whether the contract is established or not and the change of effective status.

5. 本人清楚明白贵公司的赔付款项一经通过银行成功转账在本理赔申请表所指定的帐户，将视为本人已收到该笔赔偿款项。如有其他人或法律规定享有保险金请求权的主体，就保险金与贵公司发生争议或纠纷的，本人无条件全额返还给付予本人的款项予贵公司，一切法律责任及费用由本人承担，与贵公司无关。I understand that the payment will be deemed to have been received by me upon successful bank transfer to the account specified in this claim form. If there is any dispute or dispute between your company and other people or the subject with the right to claim the insurance according to the law, I shall unconditionally return the money paid to me to the company in full, and all legal liabilities and expenses shall be borne by me and have nothing to do with your company.

就诊人/监护人签名 Signature of The Patient or Guardian: **日期** Date： 月 MM 日 DD 年 YYYY

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

本次主诉 Chief Complain of This Time：

就诊日期 Date of Service	医疗机构 Provider	病情描述或诊断 Diagnosis	类型 Type of Service		医疗费用金额 Medical Expense
			☐门诊 OP	☐住院 IP	
			☐门诊 OP	☐住院 IP	
			☐门诊 OP	☐住院 IP	
			☐门诊 OP	☐住院 IP	

首次发现该疾病或相关症状的时间 The First Time You Note the Condition or Symptom: 月 MM 日 DD 年 YYYY

主治医师签字 Signature of Treating Physician: **日期** Date: 月 MM 日 DD 年 YYYY