复星联合健康保险股份有限公司

Fosun United Health Insurance Co., Ltd.

直付理赔申请书（2025 版）

Direct Billing Claim Form（2025）

LP01-理赔申请书

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

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

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 Identification 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 Identification Number : 证件有效期 Validity Period: 月 MM 日 DD 年 YYYY 至 to 月 MM 日 DD 年 YYYY ☐长期有效 Permanent	
电话 Tel.:		

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: The Direct Payment Service only refers to our company advancing the medical expenses incurred from your current medical visit that fall within the scope of insurance liability on your behalf. For medical expenses that are not within the scope of insurance liability, exceed the corresponding expense limit, or require proportional co-payment by the insured, the hospital will settle the payment directly with you. If our company has already made the payment to the hospital on your behalf, we will contact you and request you to refund this medical visit expense in a timely manner.

反保险欺诈提示 Insurance Anti-Fraud Notice

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。Honesty and integrity constitute the fundamental principle of insurance contracts. Parties involved in insurance fraud shall be held liable accordingly

【刑事责任 Criminal liability**】**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。Engaging in insurance fraud activities may result in criminal penalties, including criminal detention, fixed-term imprisonment, and/or the imposition of a fine or confiscation of property. Appraisers and witnesses of an insurance incident who intentionally provide false supporting documents to facilitate another party's fraud shall be deemed as accomplices to the crime of insurance fraud.

【行政责任 Administrative liability**】**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。 Where insurance fraud activities are conducted but do not constitute a crime, administrative sanctions such as detention for up to 15 days or a fine of up to RMB 5,000 may be imposed. The insurance company shall not be liable for compensation or payment of insurance benefits. Appraisers and witnesses of an insurance incident who intentionally provide false supporting documents to facilitate another party's fraud shall also face corresponding administrative penalties.

【民事责任 Civil liability**】**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。Where an applicant intentionally or with gross negligence fails to fulfill the obligation of truthful disclosure, the insurance company may not be liable for compensation or payment of insurance benefits.

客户声明及客户信息授权 Authorization and Declaration

1. 本人已仔细阅读《反保险欺诈提示》，确认理赔申请书上所填写的内容真实详尽，如虚假或隐瞒，本人愿承担相应责任。I have carefully read the *Insurance Anti-Fraud Notice* and confirm that the information filled in the Claim Application Form is true and detailed. I am willing to bear the corresponding responsibilities in case of any falsification or concealment.

2. 本人同意向复星联合健康保险股份有限公司（以下简称你公司）授权下列个人信息，用于你公司及合作机构为本人提供综合服务（投保、核保、保全、理赔和回访等）、数据风控、电子签名、身份识别和验证、核保审查、理赔调查、市场调查、增值服务与信息数据分析，法律另有规定的除外：

I hereby authorize the following personal information to Fosun United Health Insurance Co., Ltd. (hereinafter referred to as "Fosun-uhi") for the purposes of providing comprehensive services (including but not limited to policy application, underwriting, policy servicing, claims settlement, and policy review), data risk control, electronic signature, identity identification and verification, underwriting review, claims investigation, market research, value-added services, and data analysis, except as otherwise provided by law：

(1)本人同意并授权你公司收集本人的姓**名、证件类型、证件号码、证件有效期限、性别、手机号、联系地址、金融账户信息、与投保人及领款人的关系、有无社保、国籍、职业、工作单位、婚姻状态、医疗健康信息、涉税信息、家庭财产信息、人脸及声音信息、保单信息、投保理赔记录、既往病史、体检信息**； I agree and authorize Fosun-uhi to collect my information including **name, type of identification document, identification number, valid period of identification document, gender, mobile phone number, contact address, financial account information, relationship with the policyholder and the claim payee, status of social insurance participation, nationality, occupation, work unit, marital status, medical and health information, tax-related information, family property information, facial and voice information, insurance policy information, insurance purchase and claim records, past medical history, and physical examination information**;

(2)本人同意并授权你公司向其合作机构提供本人的**姓名、证件类型、证件号码、保险合同、理赔申请书、病历资料和检查报告**；I agree and authorize Fosun-uhi to provide **my name, type of identification document, identification number, insurance contract, Claim Application Form, medical records and examination reports** to its cooperative institutions;

(3)本人同意并授权你公司及其合作机构向任何知悉与本次理赔服务有关的本人身体健康及其他情况的行政司法机关、公安部门、司法鉴定中心、国家金融监督管理总局及其派出机构、人社相关机构、社会医疗保险机构、体检机构、医疗机构、商业保险机构及其它单位或人员提供本人的**姓名、证件类型、证件号码、保险合同、理赔申请书**；I agree and authorize Fosun-uhi and its cooperative institutions to provide **my name, type of identification document, identification number, insurance contract, Claim Application Form** to any administrative and judicial authorities, public security departments, forensic identification centers, National Financial Regulatory Administration and its local branches, human resources and social security-related institutions, social medical insurance institutions, physical examination institutions, medical institutions, commercial insurance institutions and other entities or individuals that are aware of my health status and other information related to this claim service;

(4)本人同意并授权任何知悉与本次理赔服务有关的本人身体健康及其他情况的行政司法机关、公安部门、司法鉴定中心、国家金融监督管理总局及其派出机构、人社相关机构、社会医疗保险机构、医疗机构、体检机构、 商业保险机构及其它单位或人员将其知悉的本人发生的**保险事故的具体信息、保单信息、投保理赔记录、就诊医院、职业、诊断证明、病历信息、就诊费用、发票号、体检信息、既往病史信息**提供给你公司及其合作机构；I agree and authorize any administrative and judicial authorities, public security departments, forensic identification centers, National Financial Regulatory Administration and its local branches, human resources and social security-related institutions, social medical insurance institutions, medical institutions, physical examination institutions, commercial insurance institutions and other entities or individuals that are aware of my health status and other information related to this claim service to provide Fosun-uhi and its cooperative institutions with the specific information about **the insurance accident I have suffered (of which they are aware)**, **insurance policy information, insurance purchase and claim records, treatment hospital, occupation, diagnostic certificate, medical record information, treatment expenses, invoice number, physical examination information and past medical history information**;

(5)本人同意并授权你公司的合作机构对本人理赔阶段的信息进行必要加工、使用，并将与风险控制有关的信息处理结果回传给你公司用于理赔调查。I agree and authorize cooperative institutions of Fosun-uhi to conduct necessary processing and use of my information during the claim settlement stage, and transmit the information processing results related to risk control back to Fosun-uhi for claim investigation.

3. 在领取理赔款项后，如有其他身故保险金受益人、法定继承人或法律规定享有保险金请求权的主体，就保险金与你公司发生争议或纠纷的，一切法律责任及费用由本人承担，与你公司无关。After receiving the claim payment, if any other beneficiaries of the death benefit, legal heirs or entities entitled to claim the insurance benefit as stipulated by law have any dispute with Fosun-uhi regarding the insurance benefit, all legal liabilities and expenses shall be borne by me and shall have no connection with Fosun-uhi.

复星联合健康保险声明 Customer Information Protection

我公司及合作机构对上述信息负有保密义务。在对外传输、提供、委托处理您的信息时，我公司会要求其按照法律法规以及其他任何相关的保密与安全措施来处理您的个人信息。Fosun-uhi and the cooperative institutions are bound by confidentiality obligations regarding the above information. When transmitting, providing, or entrusting the processing of your information externally, our company will require such parties to handle your personal information in compliance with laws and regulations, as well as any relevant confidentiality and security measures.

“我已阅读并确认本理赔申请书中所有声明及授权事项”"I have read and confirm all declarations and authorizations in this claim application."

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

申请人签名 Signature of Applicant： **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