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醫院直付預先批核申請表（只適用於非尊尚醫療計劃）
HOSPITALIZATION DIRECT BILLING PRE-APPROVAL APPLICATION FORM (APPLICABLE FOR NON MASTERCARE MEDICAL PLAN)

保單號碼 Policy No. | | | | | | | | | | |

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 Particulars of Patient

1 病人姓名 Name of Patient _____ 年齡及性別 Age and Sex _____

2 身份證/ 護照號碼 I.D. Card / Passport No. _____

3 病人首次求診日 Patient first Consultation Date 年 Year ____ 月 Month ____ 日 Day ____

4 醫院名稱 Name of Hospital _____

5 預計入院日期 Expected Date of Admission 年 Year ____ 月 Month ____ 日 Day ____

6 病人家庭醫生姓名 Patient's Family Doctor Name _____

7 預計留院日數 Estimated length of stay _____ 住院級別 Bed Class ☐ 私家 Private ☐ 半私家 Semi-Private ☐ 大房 Ward

B. 疾病/受傷詳情及有關資料 ILLNESS / INJURY DETAILS AND RELATED INFORMATION

1 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

_____

_____

_____

2 發病日期 Onset date of the symptoms/conditions 年 Year ____ 月 Month ____ 日 Day ____

3 診斷 Diagnosis 國際疾病分類編碼 ICD 10 Code

_____ _____

_____ _____

_____ _____

4 是次入院/治療是否醫療需要？ Is the hospitalization/treatment medically necessary? ☐ 是 Yes ☐ 否 No

如是，請詳述。If "Yes", please give details. _____

5 根據你的評估及意見，病人就是次的病況，是否可以單從門診設施中接受適當的治療？ Given the condition of the patient, is it possible to provide this treatment on an outpatient basis?

☐ 是 Yes ☐ 否 No

如不可以，請提供原因: If "No", please explain: _____

6 此病況是否為復發性/慢性? Is the condition recurrent / chronic? ☐ 是 Yes ☐ 否 No

如"是"，請提供首次發病日期 If "Yes", please provide the onset date of the first episode:

年 Year ____ 月 Month ____ 日 Day ____

7 如是次住院/治療由意外事故引起，請提供以下詳情：If this hospitalization/treatment was caused by an accident, please provide details below:

事故發生日期 Accident Date: 年 Year ____ 月 Month ____ 日 Day ____

原因 Cause: _____

受傷位置及受傷程度 Part of body injured & extent of injury: _____

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B. 疾病/受傷詳情及有關資料(續) ILLNESS / INJURY DETAILS AND RELATED INFORMATION(Continued)

8 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址 Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. ☐ 是 Yes ☐ 否 No

轉介醫生姓名 Name of the referring doctor

轉介醫生地址 Address of the referring doctor

9 請選出與是項疾病有關之狀況。Is the illness associated with the following?

- ☐ 先天性疾病 Congenital condition
- ☐ 自殘 Self-inflicted injury
- ☐ 不育或絕育 Infertility or sterilization
- ☐ 精神紊亂 Mental disorder
- ☐ 濫藥或酗酒 Abuse of drugs or alcohol
- ☐ 性病 Venereal disease
- ☐ 視力矯正 Corrective aids or treatment of refractive errors
- ☐ 康復/療養 Rehabilitation/ convalescence
- ☐ 整容或整形治療 Cosmetic or plastic surgery
- ☐ 發育異常 Develop-mental abnormality
- ☐ 參與危險性運動/活動 Hazardous sport / activity
- ☐ 遺傳性疾病 Hereditary condition
- ☐ 一般身體檢查/防疫注射 Body check vaccination & immunization injections
- ☐ 愛滋病或人體免疫缺損病毒感染 AIDS or HIV related illness
- ☐ 懷孕，請說明預產期 Pregnancy, please provide expected date of delivery
- ☐ 其他疾病，請說明 Other disease, please specify
- ☐ 以上皆否 None of the above

10 請選出病人過往有否以下病症/習慣。Does the patient have any medical history or habit as indicated below?

- ☐ 哮喘 Asthma
- ☐ 心臟病 Cardiac problem
- ☐ 糖尿病 Diabetes Mellitus
- ☐ 乙型肝炎 Hepatitis B
- ☐ 高血壓 Hypertension
- ☐ 曾接受手術 Previous operation
- ☐ 濫藥 Drug abuse
- ☐ 家族性癌症 Family history of cancer
- ☐ 家族病史 Unfavorable family history
- ☐ 以上皆沒有 None
- ☐ 其他疾病，請說明 Other disease, please specify

11 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療 ？ 如有，請說明詳情。Had the patient previously been treated or hospitalized due to the above disease or other major disease? If so, please specify details.

☐ 有 Yes ☐ 沒有 No 診治日期 Date of diagnosis/treatments 年 Year 月 Month 日 Day

疾病 Disease

治療/住院詳情 Details of Treatment / Hospitalization

醫生姓名/醫院名稱 Name of Physician/Hospital

12 請提供飲酒/吸煙習慣詳情 Please provide details of drinking & smoking habit

每日用量(支/包/樽/罐) Daily consumption (piece/ pack/ bottle/ can)

習慣始自 Drinking/ Smoking start date since 年 Year 月 Month 日 Day

C. 治療詳情及預計費用 TREATMENT DETAILS AND COST ESTIMATION

1 治療計劃或手術名稱 Treatment plan or Surgical procedure name

麻醉 Anesthesia

☐ 全身麻醉 G.A. ☐ 局部麻醉 L.A. ☐ 監測麻醉 M.A.C

2 建議之化驗 / 影像檢查 / 其他診斷性檢查及接受該等檢查的原因。Please list out any Lab tests/Imaging/other diagnostic investigations required for this hospitalization and reasons for the same.

3 是否可以單從門診設施中接受該等檢查？如否，請解釋原因 Can the investigations be carried out in the outpatient setting? If no, please explain why.

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C. 治療詳情及預計費用(續)TREATMENT DETAILS AND COST ESTIMATION (Continued)

4 是次提供的治療、治療程序、檢測是否為尚未能確定成效或屬實驗性質或仍在試驗階段的治療? Has the treatment, procedure or test not yet been established as being effective or is experimental or is in trial stage? ☐ 是 Yes ☐ 否 No

如是，請詳述並提供原因 Please provide details:

5 治療預計費用 Cost estimation of treatment:

住房及膳食費 Room and board	HK$		每日 Per Day
主診醫生巡房費 Attending physician's Visit Fee	HK$		每日 Per Day
外科醫生費(請列出明細；如有) Surgeon's Fee (with breakdown; if any)	HK$		
麻醉師費用(請列出明細；如有) Anaesthetist's Fee(with breakdown; if any)	HK$		
手術室費用 Operating Theatre Fee	HK$		
醫院雜項費用 Miscellaneous Expenses	HK$		
其他費用(例如專科醫生費及其他) Other Expenses (e.g. specialist fee etc.)	HK$		
入院前及出院後之門診護理 Pre and post hospitalization outpatient follow up	HK$		
預計總費用 Total estimate fee	HK$		

D. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

本人謹此聲明，就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。本人已向病人解釋上述預算費用，並徵得其同意。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief. I have explained to the patient the details of the above estimated charges and have sought his / her agreement.

主診醫生姓名 Name of Attending physician		資歷 Qualification			
地址 Address		聯絡電話 Contact No.			
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and Stamp of Hospital/ Clinic		日期 Date	年 Year	月 Month	日 Day