Bupa Health Insurance Scheme Pre-authorisation Form
保柏醫療保障計劃初步保障審核表格

Bupa 保柏

Hotline 查詢熱線 (852)2517 5789 **Email 電郵** approvalsvc@bupa.com.hk **Fax No. 傳真** (852)3973 6966 Plesae complete this form and send to Bupa by email or fax 請填妥此表格並電郵或傳真至保柏

Part I - To be Completed IN FULL by Member 第一部分 - 由會員填寫全部資料

Insured's Name 受保人姓名	Date of Birth 出生日期 (DD日 / MM月 / YY年)
BOC Life Policy No. 中銀人壽保單編號	Tel No. 電話號碼
Bupa Membership No. 保柏會員編號	

Authorisation and Declaration 授權及聲明

I hereby declare that the below information given is true and correct. I hereby authorise any medical practitioner, hospital, clinic, by whom or where I / the Member have been observed or treated or any insurance company or organisation that has any records or health information concerning me / the Member for any reason, to give full particulars thereof including prior medical history to Bupa. A copy of this authorisation shall be considered as effective and valid as the original.

本人謹此聲明，以下所填報之一切資料，均屬真確無訛。本人謹此授權任何為本人 / 會員觀察或治療的醫生、醫院、診所，或持有本人及 / 或會員健康或任何資料之保險公司或機構將本人及 / 或會員之資料 (包括病歷) 交予保柏，本授權書之副本與正本具同等效力。

I understand that a shortfall may occur if the final costs for treatment exceed my plan coverage or the medical expenses are not eligible for reimbursement, I agree to reimburse to Bupa any shortfall incurred.

本人明白若最終的治療費用超過本人的保障額，或有關費用不屬於保障範圍內，本人同意全數歸還因此所產生的任何差額給保柏。

Personal Information Collection Statement 個人資料收集聲明

I have read and understand the Personal Information Collection Statement on the last page of this form.

本人已細閱並明白本表格最後一頁的個人資料收集聲明。

Signature of Member / Guardian 會員 / 監護人簽署	Name 姓名	Date 日期 (DD日 / MM月 / YY年)
X		

Part II - To be Completed IN FULL by Attending Doctor 第二部分 - 由主診醫生填寫全部資料

1. Chief Complaint of the Current Consultation : ..... Onset date ... / ... / ... (DD / MM / YY 日 / 月 / 年)
   本次就診之主訴　病徵出現日期
2. Findings of the Physical Examination : .....
   醫生檢查之所見
3. Diagnosis 診斷： .....
4. Name of Referring Doctor / Usual Doctor : ..... (Tel / fax : .....)
   轉介 / 家庭醫生之姓名　電話 / 傳真

Was the medical condition caused by or related to the following 此病是否與下列情況有關或引致？

- ☐ accidental bodily injury 身體意外受傷
- ☐ abuse of drugs or alcohol 濫用藥物或酒精
- ☐ AIDS, HIV, sexually transmitted disease 愛滋病，人類免疫力缺損，性病
- ☐ pregnancy, infertility or sterilisation 懷孕，不育或絕育
- ☐ treatment for cosmetic purpose 美容治療
- ☐ mental or nervous disorder 精神或神經疾病
- ☐ self-inflicted injury 自我傷害
- ☐ congenital, hereditary, developmental condition 先天性，遺傳性或發育異常
- ☐ general check-up or vaccination 一般身體檢查或防疫注射
- ☐ none of the above 以上皆否

Treatment Details 治療詳情

Laboratory Test and Imaging 化驗及影像學檢查

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☐ Pre-operative assessment (Please also provide the information on the surgery at the space below) 手術前評估（請於下列空格內提供手術之資料）　☐ Routine check-up 常規身體檢查

Date of investigation 檢查日期 ... / ... / ...　Location 地點 .....　Cost (HKD) 費用 (港幣) .....

Diagnostic / Surgical Procedures 診斷性 / 外科手術

Procedure Name and Code 手術名稱及編碼	Anaesthesia 麻醉	Location 地點	Cost 費用
	☐ GA 全身麻醉 ☐ MAC 監察麻醉 ☐ LA 局部麻醉 ☐ IVS 靜脈注射鎮靜	☐ Clinic 診所 ☐ Day Case 日症 ☐ Hospital OPD 醫院門診部 ☐ In-patient 住院	HKD 港幣
	Date of Treatment 治療日期	Name of Hospital / Day Case Unit 醫院 / 日症中心名稱	
	/ /		

If Hospitalisation is required 如需住院：

Hospital Name 醫院名稱 ..... Bed class 住房級別： ☐ Private 私家 ☐ Semi-private 半私家 ☐ Ward 大房

Date of admission 入院日期 ... / ... / ...　Estimated length of stay 估計留院日期 ..... days 日　In-patient physician fee 住院醫生費用 HKD 港幣 ..... / day 每日

Treatment Plan 治療計劃 .....

If hospitalisation is arranged for scans, diagnostic testing or a procedure that is normally carried out in a day case, please explain why hospital stay is necessary.

如是次住院之目的為檢驗，進行診斷掃描或一般日症手術，請說明留院之原因。

.....

Non-Network Specialist Referral 轉介非網絡專科醫生 (where the relevant Specialty is not provided in the Network 如網絡內未有提供有關服務之專科)

Specialty 專科 .....　Name of Specialist 專科醫生姓名 .....　(Tel / fax : 電話 / 傳真 .....)

Reason for Referral 轉介原因

Doctor's Particulars and Signature 醫生資料及簽署

Doctor's Name 醫生姓名	Doctor's Chop & Signature 醫生蓋印及簽署	Bupa Provider Code (if any) 保柏醫生編號 (如有)
Date 日期	X	Bupa Network Identifier (if any) 保柏網絡編號 (如有)

Confirmation of authorisation should be returned to 初步保障審核結果須送遞如下：

Fax No. 傳真號碼： .....　Contact Telephone No. 聯絡電話： .....

Personal Information Collection Statement 個人資料收集聲明

I understand and agree that all personal and medical information relating to me / the Member contained in this pre-authorisation application will be used by Bupa for the purpose of (1) processing this application and providing subsequent services; (2) processing any claims analysis and / or medical, identity or other insurance-related checks; (3) data matching, statistics, research, reporting and auditing; (4) communication with me about this pre-authorisation; (5) exercising the right to determine indebtedness, collecting and recovering amounts owing by me or any person who has provided any security or undertaking for my liabilities; and (6) satisfying any applicable legal or regulatory requirements.

I agree that such information may be transferred for the above purposes to any of the following parties (within or outside Hong Kong): any of the private hospital(s) specified in Part II, Bupa's group companies, any insurance intermediaries as authorised by myself and Bupa, any re-insurance companies authorised by Bupa, any claims investigation companies, any service providers providing services to Bupa, any association or federation relating to the insurance industry, and any person or organisation as required by law.

Consequences of non-provision of personal information: I understand that Bupa may be unable to process this application if I fail to provide any information requested in this application or otherwise by Bupa.

My rights in respect of my personal information: I further understand that (1) under the Personal Data (Privacy) Ordinance, I shall have the right to request access to and correction of any personal information concerning me provided to Bupa, by writing to Bupa's Data Protection Officer at 6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong or by other means as Bupa may notify me from time to time. (2) I also have the right to request Bupa to cease using my personal information for direct marketing purposes by writing to Bupa's Data Protection Officer, by registering online at http://www.bupa.com.hk/ unsubscribe.asp or by calling the Customer Care team.
The detailed version of Bupa "Personal Information Collection Statement" may be obtained on Bupa's website at http://www.bupa.com.hk/eng/Others/legal-notices.aspx

本人明白及同意保柏透過此初步保障審核申請收集之本人 / 會員之個人及健康資料，可供保柏用作以下用途 (1) 處理此申請及提供有關服務；(2) 處理任何索償分析及 / 或與醫療、身份或其他保險有關的查核；(3) 資料核對、統計研究、報告及審計；(4) 就此初步保障審核與本人聯絡；(5) 行使本公司向閣下或屬下會員提供保險和相關服務及產品而享有的權利，例如釐定欠付閣下或閣下拖欠的任何款項的金額，及向閣下或任何已為閣下的債務提供任何擔保或承諾的人士，追收和收回拖欠的任何款項；及 (6) 遵守任何法例或監管要求。

本人同意該等資料可因上述用途提供予下述任何各方(不論在香港境內或境外)：任何列於第二部分之醫院、保柏的集團公司、任何由本人及保柏授權的保險代理人、任何由保柏授權的再保險公司、賠償調查公司、任何向保柏提供服務的供應商機構、與保險業相關之團體及任何法律要求的任何人士及團體。

未能提供個人資料的後果：本人明白若本人不能提供此申請或保柏要求的其他資料，保柏不能處理此申請。

有關個人資料的權利：本人明白(1)根據個人資料(私隱)條例，本人有權就查閱及修正保柏所持有關於本人的任何個人資料致函保柏之保障資料主任，地址為：香港九龍觀塘海濱道77號海濱匯第2座6樓或按保柏不時通知本人的其他途徑遞交。(2)本人亦可透過網站http://www.bupa.com.hk/unsubscribe.asp進行登記或致電保柏客戶服務專線，以要求保柏停止將本人的個人資料作直接市場推廣用途。

有關個人資料收集聲明之詳情，請參閱保柏之網站 http://www.bupa.com.hk/chi/Others/legal-notices.aspx