中国平安 PING AN

专业 · 价值

理赔单（直接结算用）

Claim Form for Direct Billing

客户填写部分：To be completed by client:

1、 出险者信息 Details of the insured

出险者姓名 Insured name			
投保单位 Policyholder	非团险客户无需填写 Individual insureds do not need to fill in this block		
证件类型 ID type	☐ 身份证 ID card ☐ 护照 Passport ☐ 其他 Other _____		
证件号码 ID number		证件有效期至 ID expiry date	YYYY/MM/DD
国籍 Nationality		职业 Occupation	
分单号 Sub-policy number		如有分单号优先填写分单号，如无分单号请填写保单号。If sub policy number is unavailable, please fill in the policy number	
电子邮件 Email address			
联系电话 Telephone number	-	手机号码 Mobile number	
邮寄地址 Postal address			
扣款账号 Bank account number		邮政编码 Post code	
银行名称 Bank name		分行 Branch	

提示：直结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或者本应从保险金中扣除的欠交保费等，应由您负担但医院未向您收取的，您应当将上述相应款项退还本公司。您已知悉并同意我司从上述帐户中扣除我司为您垫付的您应退还的医疗费用。

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 or any payments you have to make but were not collected by the hospital. Any premiums that are in arrears will also be deducted from the benefit payment. You have been notified, and you agree that we will debit your bank account (details provided above) for the medical expenses that we have paid and that you have to refund to us.

2、被保险人授权及声明书 Authorization and declaration of the insured

个人声明

1. 本人确认理赔申请书上所填写的内容真实详尽。
2. 本人同意将本次理赔申请的保险金转入本次申请确认的本人银行账户或授权的第三方银行账户，由该账户所有人代为领取保险金，因本人或申请人过错导致转账错误、转账不成功、未及时或未全额收取理赔款的，贵公司不承担责任。
3. 本人同意：从本次理赔的合理保险给付金中，扣除尚未偿还的不属于保险责任范围但保险公司已为本人向医院垫付的医疗费用。

客户个人信息授权声明

1. 为准确识别本人投保信息之所需，本人同意并授权平安健康保险股份有限公司（下称“平安健康保险”）收集**报案人/投保人/被保险人的姓名、证件类型、证件号码、性别、手机号、地址、账户信息、与被保险人的关系**等必要信息。
2. 为申请理赔之所需，本人同意并授权平安健康保险及其合作的医疗机构、药店等第三方机构收集、共享被保险人的理赔申请相关资料，包括但不限于**出险描述、所在医院、职业、诊断证明、病历信息、就诊费用、发票号**等信息。
3. 为进行理赔调查之所需，本人授权上海保险交易所股份有限公司及其医疗合作伙伴（下称“信息收集方）根据平安健康保险开展精准核保、风险防控服务的申请，向合法持有与本次理赔相关的本人及被保险人健康信息的机构查询相关健康信息并提供给平安健康保险，可查询的健康信息仅限于**医疗记录、体检信息、既往病史**。平安健康保险与信息收集方将对查询的健康信息严格保密，未经本人授权同意，不得向其他第三方提供、泄露。
4. 本人知晓并同意，如本人拒绝提供上述信息，平安健康保险股份有限公司将无法确认本人的身份及保单信息以完成相关理赔手续。本授权声明未尽事宜按照投保时《隐私政策》及相关附属规则予以履行。
5. 本人已知晓直结服务仅为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、应当由本人按比例自付的医疗费用或者本应从保险金中扣除的欠交保费等，应由本人负担但医院未向本人收取的，本人必须承担此费用。本授权的影印本同样有效。

Declaration

1. I declare that all information provided on this Claim Application Form and the documents submitted with it are true and accurate to the best of my knowledge.
2. I agree that reimbursement for this claim will be made into the bank account of the insured or into the bank account authorized on this application, and that the account holder is entitled to receive the reimbursement. Ping An Health will not be responsible for errors or failed, delayed or incomplete payments due to mistakes on the application form or having the incorrect bank account details.
3. I agree that the medical expenses that Ping An Health has already paid to the hospital, and which are not covered by my insurance policy, will be deducted from the benefit payment for this claim.

Clauses on Individual Information Authorization

1. I agree and authorize Ping An Health Insurance Company of China, Ltd. (hereinafter referred to as "Ping An Health") to collect necessary information such as **name, ID type, ID number, gender, mobile number, address, account information and relations with the insured of the claimant/ policy holder/ the insured**, for the purpose to accurately identify my insurance information.
2. I agree and authorize Ping An Health and its partner medical institutions, pharmacies and other third-party institutions to collect and share relevant materials of the insured's claim application, including but not limited to **incident description, hospital, occupation, certification of diagnosis, medical record information, medical expenses, invoice number**, for the sake of claim application.
3. I authorize Shanghai Insurance Exchange Co., Ltd. and its medical partners (hereinafter referred to as "information collectors") , for the purpose of claim investigation, to query relevant health information from the institution that legally holds the health information of the insured's and myself related to the claim, and provide it to Ping An Health, according to Ping An Health's application for conducting accurate underwriting and providing risk prevention and control services. The health information that can be inquired is limited to **medical records, health check-up information and past medical history**. Ping An Health and the information collectors shall keep the health information inquired strictly confidential and may not provide or disclose it to other third parties without my authorization and consent.
4. I understand and agree that, if I refuse to provide the above information, Ping An Health will not be able to confirm my identity and insurance information to complete relevant claim procedures. Matters not mentioned in this authorization declaration shall be performed in accordance with the Privacy Policy and relevant pertaining rules at the time of insurance application.
5. I acknowledge that the direct billing service is only to advance the medical expenses incurred in this medical treatment within the insurance coverage. For uncovered medical expenses, medical expenses beyond the corresponding limit, copay, premium in arrears and others that should have been deducted from the insurance premium, or expenses that should be borne by myself but not charged by the hospital, such expenses must be borne by myself. The copy of this authorization shall be considered as effective and valid as the original.

被保险人/监护人签名 Signature of the insured or guardian _____ 日期 Date: YYYY/MM/DD

3、反保险欺诈提示 Anti-fraud notice

诚信是保险合同基本原则，涉嫌保险欺诈将承担以下责任。This insurance agreement is formed on the basis of integrity. Any suspicion of insurance fraud will carry the following 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。Any criminal activities involving insurance fraud can lead to: detention, imprisonment and other penalties such as a fines or confiscation of personal property. Appraisers or witnesses of an incident who intentionally provide false documents or information to allow others to defraud the insurer will be treated as accomplices in the insurance fraud.

【行政责任Administrative liabilities】进行保险诈骗活动，尚不构成犯罪的，可能会收到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。Those who conduct insurance fraud that does not constitute a crime will be subject to administrative punishment such as detention of up to 15 days or a fine of up to RMB 5 000. Appraisers or witnesses of an incident who intentionally provide false documents or information to allow others to defraud the insurer will be treated as accomplices in the insurance fraud.

【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 an applicant fails to provide true statements, either intentionally or due to gross negligence, the insurer will not reimburse or pay insurance benefits.

由主治医生填写: To be completed by the attending physician：

4、保险金给付信息 Medical information

医院名称 Hospital		就诊日期 Date of treatment	

简述主诉及诊断 Briefly state the nature of the illness or symptoms
(如已提交病历复印件，此部分可不填写 Only to be completed if a copy of the patient's medical record is NOT provided)

上述病症或症状是否与任何意外事故或患者的工作职责有关？Is this accident or injury related to the patient's employment duties?	☐ 没有 No ☐ 有 Yes 勾选此项，请说明 If "Yes", please give more details:
患者之前是否曾患过类似疾病/症状或相关症状 Has the patient ever suffered from this condition, symptoms or related conditions before?	☐ 没有 No ☐ 有 Yes 勾选此项，请说明 If "Yes", please give more details:

首次出现时间 Date of first symptoms		首次就诊时间 Date of first treatment		首次就诊医院 Hospital where first treated	

5、账单信息 Medical expenses

总计金额 Total amount:		诊疗费 Consultation amount:	
客户自付金额 Self paid amount:		手术费 Surgery expenses:	
医院垫付金额 Direct billing amount:		药费 Drug or medicine amount:	
备注 Note:		检查费 Examination and laboratory amount:	
		治疗费 Treatment amount:	
		其他费用 Other amount:	

医生签名
Signature of attending physician _____ 日期 Date: YYYY/MM/DD