GBG Member Claim Form

GBG 会员理赔申请表

This claim form is to be used only if your provider did not file claims directly to GBG on your behalf. Return this form ***along with fully itemized bills and diagnosis*** to the address below. GBG China suggests all your eligible claims to be submitted within one hundred eighty days (180) after your first treatment date.
尊敬的会员，如果您未使用直付服务在医疗机构直接结算。为了确保您提交的理赔申请是有效的，请填写本表后，**连同完整的收费清单及诊断证明**，寄往如下地址。GBG 中国理赔服务中心建议在治疗结束起的（180）天内，尽快提交理赔申请。

GBG China Claim contact information/ GBG 中国理赔服务中心联系信息：
Suite 2104,SCG Datang International Plaza, 868 Yinghua Road, Shanghai 201204, P. R. China
中国上海市浦东新区樱花路 868 号建工大唐国际广场 2104 室 邮编 201204；
Tel 电话: 86 400 816 9300; Fax 传真: 86 21 2601 5791; Email 电子邮件: chinaservice@gbg.com;

Section A: Primary Insured and Patient Information – Please fill out the form completely, otherwise your reimbursement will be delayed.
第一部分：主被保险人与就诊人信息 – 请务必完整填写，否则将造成理赔款支付延误

Patient's name 就诊人姓名：	Primary insured name 主被保险人姓名：
GBG Member number GBG 会员编号：	Full Name of the Policyholder （only applicable on group member） 雇主全称（团体会员适用）：
Date of birth (YYYY/MM/DD) 生日(年/月/日)：	Address 地址：
Email 电邮：	Telephone 电话：

Have you submitted the claim through another health insurance policy? 您是否使用其他健康保险的保单申请过同样的理赔？ □ Yes 是 □ No 否

If yes, please provide name of other insurance company and a copy of your policy 如是，请提供保险公司名称及保险计划的副本：

Section B: Medical information
第二部分：医疗信息

Date of Service 就诊日期	Hospital 就诊医院	Diagnosis or Symptoms 疾病诊断及症状	Amount and Currency 发票金额及币种

I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to GBG/Tiecare International as is required to properly pay all benefits, if any, due me, my spouse, or family members of this claim. A photocopy of this authorization shall be considered effective and valid as the original.
为了使我、配偶及家人得到应获的保险理赔，本人在此授权任何医生、医疗机构、药店、保险公司、工会、雇主等相关单位，将任何与此保险理赔要求的相关资料提供给 GBG/Tiecare。本批准书的影印件应被视为与原件同样有效。

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing false, incomplete or misleading information is guilty of a felony.
欺诈声明：任何故意损害，欺骗或欺诈保险公司，提供含有虚假信息、不完整信息或误导信息的理赔申请都需要承担法律责任。
If the insurer finds the above activities, the insurer is entitled to take back the paid claim reimbursement of the case from the insured.
如保险人发现被保险人有上述行为，保险人将暂缓支付理赔。保险人有权追回已经支付的涉案保险金。

I declare that all the information I provided for this consultation is true and I also hereby confirm that I have reviewed and signed for all other related information including medical description that doctor recorded. I understand that changing the information may lead to a payment delay, partially denial or whole denial.
本人确认本次就诊中所描述的所有信息属实，并已签名确认医生所记载的与本次就诊相关的其他的病历资料也属实。本人了解更改相关病历资料会造成理赔款的支付延误、部分拒赔甚至全部拒赔。

*Handwritten signature of the Insured Person 被保险人手写签名 (or Parent/Guardian if under 18) (如未满 18 周岁，请法定监护人签名）	* Date 日期

Section C: Payment Information – Please fill out the form completely, otherwise your reimbursement will be delayed.
第三部分：付款信息 – 请务必完整填写，否则将造成理赔款支付延误

Please make payment to: ☐ Member ☐ Provider 请支付至: 被保险人 医疗机构	Please choose payment type: ☐ wire transfer ☐ Cheque 请选择支付类型: 银行转账 支票
1. Bank transfer 银行转账	
Name on account 开户人姓名： （Please provide the exact name used during account opening, including case sensitive, punctuation and space.） (请使用正确的开户名称，并区分英文字母大小写，标点符号及空格)	Account No. 账号：
Bank Name (including branch name) 开户银行及分行名称：	Subbranch Name 开户银行支行名称：
SWIFT code	Routing number (ABA)
2. Cheque 支票: (Cheque is only applicable to overseas claims reimbursement 支票仅适用于境外理赔申请) Please provide detail address to receive cheque 请提供收取支票的地址	

•Please check with your local bank as there may be a fee for the transfer service. 请与您的当地银行核实服务费收取情况。

Section D: Medical information- to be completed by the treating physician
第四部分：医疗信息 – 由主治医生填写

This section can be left blank if the claim information are accompanied by relevant medical information. 如理赔材料中已经附有相关理赔材料，则此栏可以不用填写。

Chief complaint and on what date (month / year) did you first notice the conditions or date of the symptom appear? (Please describe the symptoms) 主诉及该疾病第一次发生的时间或者相关症状：
Please provide the details of the treatment received, and when the treatment began 对于已接受过治疗的疾病，请提供治疗开始的时间及治疗的详细信息：
Diagnosis / Impression 诊断/印象：
Treatments Details 治疗措施：

Medical Practitioner Declaration:
医生声明：
I declare that I am the patient's Medical Practitioner, and that the particulars given are, to the best of my knowledge, true and correct.
谨此声明，本人是就诊人的医生，就本人所知及所信，所填资料均正确无误。

Treating doctor's signature: 主治医生签字：	Official stamp: 官方印章：
Date（YYYY/MM/DD）: 日期 (年/月/日)	