

# Pre-Authorization Request Form

## 事先授权表

COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS AUTHORIZATION REQUEST. 提交事先授权，请协助完整地填写以下表格。

If not a medical emergency as defined by your policy contract, you must wait until you have a written authorization from GBG Assist before proceeding with any procedure requiring pre-authorization. Please see your policy for a list of those procedures, or visit [www.gbg.com](http://www.gbg.com). Otherwise, penalty co-pay will apply to your claims, and the provider may decline to direct bill us. 若为合同条款定义的非急诊且需要事先授权的治疗，则需在收到 GBG Assist 授权担保函后才可进行。您可以参照条款合同或在 GBG 网站 [www.gbg.com](http://www.gbg.com) 上查参考需要事先授权的治疗列表。否则，被保险人需要支付相应的处罚金，并且网络直付医院可能会拒绝提供直付服务，需要您做事后理赔。

Section A. Patient information please write legibly 病人信息	
Name (Last, First, MI) : 姓名:	Alias: 别名:
Date of Birth (MM/DD/YY) : 出生日期 (月/日/年) :	Policy ID Number: 保险号码:
Contact Email: 邮箱:	Phone Number: 联系电话:
Diagnosis, Symptom, or Complaint (medical necessity for requested procedure): 医疗诊断, 症状或主诉 (申请治疗的必要性) :	
Is the patient having surgery? 是为病人申请手术吗? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 If Yes, what type of anesthesia is required? 如果“是”，需要进行何种麻醉? <input type="checkbox"/> Local 局部 <input type="checkbox"/> General 全身 <input type="checkbox"/> Or Sedation 或镇静状态	
Expected surgery/inpatient admission date (DD/MMM/YYYY): 预期手术/住院病人入院时间 (年/月/日) :	
Is the patient being admitted to the hospital overnight? If yes, expected number of days / duration: <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是为病人申请住院治疗吗? (如果“是”请写明估计住院天数) :	
Procedure or treatment name: 申请治疗项目的名称:	
Expected date of surgery or inpatient admission (MM/DD/YY): 预计手术治疗或住院日期 (月/日/年) :	
Anticipated type of delivery (for maternity admissions only): <input type="checkbox"/> Vaginal 顺产 <input type="checkbox"/> Cesarean Section 剖腹产 预计分娩方式 (仅因分娩住院填写) :	
Estimated cost : 估计费用:	Currency : 货币:
Hospital/Facility : 医院/医疗机构名称:	Physician/Surgeon: 内科/外科医生姓名:
Hospital location: 医院地址:	Tax ID Number (USA Doctors Only): 税号 (仅美国医院) :
First date injury, illness, or accident occurred (MM/DD/YY) : 受伤, 生病, 或意外发生的日期 (月/日/年) :	
Describe how accident occurred if applicable : 如适用, 请描述意外如何发生	
First date you ever received treatment this condition (MM/DD/YY): 您曾经因此问题第一次就诊的日期 (月/日/年) :	
Describe previous treatment(s) received for this condition, if any, including dates (ex. medicines, consult, surgery, hospitalizations and conservative treatments): 如果以前进行过治疗, 请描述一下此疾病先前的治疗情况, 包括日期 (如药物、会诊、手术、住院及保守治疗) :	

**Section B. Physician information 医生信息**

Physician/ Surgeon Name: 主治医生/外科医生姓名:	Tax ID Number (USA Doctors Only): 税号 (仅美国医院):
Address : 地址:	
Telephone Number: 电话:	Email: 邮箱地址:

PLEASE ATTACH ANY AVAILABLE INITIAL EXAM AND/ OR DIAGNOSTIC REPORTS TO SUPPORT THE MEDICAL NECESSITY OF THIS REQUEST.  
请附上检查和/或诊断证明的原件以证明此申请治疗的必要性。

**Section C. Signature 签名:**

**Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**  
**任何人明知索赔材料中包含任何不实陈述或虚假信息, 不完整或误导性信息的, 皆为犯罪行为并会根据法律得到惩处, 并可能受到民事处罚。**

Signature 签名:	Date 递交日期:
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If you have any inquires on the pre-authorization, please feel free to contact us through chinapreauth@gbg.com or the following hotline or WeChat online services.

若您对事先授权有任何疑问, 您可以发邮件至 chinapreauth@gbg.com, 拨打以下热线电话或联系我司微信平台进行查询。

Greater China: 86-400-816-9300  
大中华地区: 86-400-816-9300

U.S and Canada: 1-866-914-5333  
美国和加拿大: 1-866-914-5333

Rest of the world: 1-905-669-4920  
其他地区: 1-905-669-4920