MGU Member Claim Form
MGU会员理赔申请单
MEDILINK-GLOBAL
中间带（北京）技术服务有限公司
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总公司地址： 北京市朝阳区建国门外大街丙24号京泰大厦10层
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上海公司地址：上海市静安区万航渡路623弄85号建华大楼3F
24-Hour Hotline
24小时服务热线：400 114 9606； +8610 6552 5313
Fax(For Claim)
传真（理赔专用）：+8610 8453 9719

Please fill the information carefully based on facts, incomplete or false information will cause payment delay or decline.
请填写真实信息.不完整或不真实的信息将造成付款的延期

## A PATIENT DETAILS 患者信息

To be completed by the insured or guardian
由被保险人或家属填写

Name of Patient 病人姓名（必填） | Healthcard No. 保险卡卡号（必填） | Tel 联系电话（必填）

ID/Passport No./Date of Birth(MM/DD/YY) 身份证/护照号/出生日期（月/日/年）（必填） | Name of Company 公司名称 | E-mail 邮箱地址

Do you need the invoice back from insurance company if you have any self-pay amount?
如有自付额，是否需要保险公司退还医疗费用发票?
If Yes, please leave your detailed address. 如果选择是，请详细填写收件地址。
☐ Yes是 ☐ No否

Have you ever 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?
If yes, please provide the name of the 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：
☐ Yes是 ☐ No否

Payment Information—please fill the information carefully, otherwise it will delay the payment.
付款信息——请务必完整清晰填写，负责将造成付款的延期

Pay to请支付： ☐ Insured Person被保险人 ☐ Medical Provider医疗机构

Bank Information 银行信息

Bank Name开户行名称： | Account Name开户行姓名： | Account No.账号：

SWIFT Code (if needed) 银行汇款代码： | Bank Address银行地址：

Statement of Consent

I agree that, for any reason, I will pay the full amount of any fees that my insurance policy does not cover during my direct billing service. I agree that Medilink or my insurance company contact me and collect the fees from me via my bank transfer. I further agree that if I do not pay these fees in time, I will be personally responsible for all costs of the collection, which include any reasonable legal costs, related costs incurred by insurance company, Medilink and /or the medical facility.

For the necessity of underwriting, claim and related service, I agree that insurance company, medical facility and Medilink share my related insurance benefit, health and/or medical information. I authorize any physician, medical facility, pharmacist, insurance company, employer, labor union, or association to release such information to Medilink and my insurance company. The information includes copies of medical records, concerning advice, care or treatment plan. I hereby confirm that the above statements are true and complete. For the necessity of claim and related service,I agree that the insurance company or Medilink handle the claims money on my behalf.I agree to provide any additional information as further required.
For Direct Billing case or guaranteed case which the medical treatment received in the pre-appointed provider,I hereby authorize the provider or pre-appointed third party to directly bill my insurance company which should make payment of any benefit payable to the provider or pre-appointed third party.
A photocopy of the above authorization shall be considered as effective and valid as original document.

确认条款

我同意，在任何情况下，保险保障所不包含的医疗费用及服务等将由我本人足额支付。我同意由保险公司或者中间带直接联系我并通过银行转账的方式收取。如果我不能按时支付，我将承担由此产生的额外费用，包括合理的法律诉讼费用、保险公司、中间带或医疗机构向我收取此费用过程所产生的其他费用等。

我同意因理赔或相关服务需要，保险公司、医疗机构及中间带可以分享与我本人有关的保险福利、健康、医疗信息及资料。我同意任何医生、医疗机构、药剂师、保险公司、雇主、工会或协会将我就诊治疗、接受护理的相关病历、病史等资料信息（包括复印件）提供给中间带。我同意因理赔或相关服务需要，由保险公司或者中间带代我处理理赔款。我在此确认以上声明和授权真实完整，我本人愿意进一步提供其他所需信息。
对于发生在事先约定的医疗机构内，针对特定的或本保险人已经事先担保的医疗项目，本人在此授权该医疗机构或预先指定的第三方代表本人向保险人索赔，保险人应该直接支付给该医疗机构或指定的第三方。

以上授权的复印件与原件视为同等效力。

Signature of Patient 患者签名 | Signature of Deputy 代理人签名 | Relationship with Patient 代理人与患者关系 | Date 日期

Please fill the information carefully based on facts, incomplete or false information will cause payment delay or decline.
请填写真实信息.不完整或不真实的信息将造成付款的延期

## B MEDICAL INFORMATION 医学信息

To be completed by Attending Physician
由主治医师填写

CHIEF COMPLAINT (REQUIRE)
主诉（必填）

HISTORY OF PRESENT ILLNESS (REQUIRE)
现病史（必填）

PAST MEDICAL HISTORY (REQUIRE)
既往病史及发现 （必填）

If the patient suffered from this condition previously, please indicate the time and treatment
如果此病症已有既往史，请注明上次的发病时间并简述治疗情况

☐ HEALTHY 体健 ☐ HYPERTENSION 高血压病史 ☐ CORONARY HEART 冠心病史
☐ DIABETES 糖尿病史 ☐ ANAPHYLAXIS 过敏史 其他：

CHECK UP / INVESTIGATION RESULT
检查/化验结果

This will include, but not limited to: Lab Test,X-Ray,CT Scan/MRI
此项包括但不仅限于：化验室检查、X光、CT、核磁共振检查

DIAGNOSIS
诊断

For the diagnosis and prescription
请与处方对应

Patients required drug or test
是否有患者要求的带药或检查? ☐ 是 ☐ 否

TREATMENT / DRUGS
治疗及用药 （处方）

Please specify the quantity, as well
请注明用量

声明书Statement of Declaration

I hereby certify that the details above are full, complete and true
特此证明以上填写的资料完整并属实

Clinic Stamp
诊所盖章

Signature of Attending Physician
主治医师签名

Date / /
日期 DD 日 MM 月 YY 年

MEDILINK Copy
中间带保留