中国平安 PING AN
金融 · 科技

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			
		邮政编码 Post code	
扣款账号 Bank account number			
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、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.

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

本人，为被保险人（或其监护人），确认本申请书中的各项信息（包括医疗信息和结算金额）真实无误，并已阅读《反保险欺诈提示》，同时在此授权平安健康保险股份有限公司可要求持有或了解本人的健康及医疗记录，自行或委托第三方调查机构，向曾为或将为本人诊治的有关人士、医疗机构或其他团体，收集本人健康及医疗相关资料。由平安健康保险股份有限公司收集的上述资料，可使用、储存、透露给本人雇主或其他有权单位，以作为赔偿评估及医疗保险之用途。如本人为平安集团及其合作伙伴的被保险人，将同时授权平安集团及其合作伙伴可要求持有或了解本人的健康及医疗记录、曾为或将为本人诊治的有关人士、医疗机构或其他团体，向平安集团及其合作伙伴透露健康及医疗相关资料。由平安集团及其合作伙伴收集的上述资料，可使用、储存、透漏给其他有权单位，以作为赔偿评估及医疗保险之用途。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。

I, as the insured (or his/her guardian), confirm that the information in the application (including medical information and settlement amount) is authentic, and I have read the Anti-Insurance Fraud Tips. Hereby I agree that Ping An Health may request to hold or get to know my health and medical records, or by itself or entrusting a third-party investigation institution, collect my personal health and medical data from relevant persons, medical institutions or other organizations that have provided or are going to provide medical services to me. The above-mentioned information collected by Ping An Health may be used and stored by and disclosed to my employer or other authorized entities for the purpose of compensation assessment and medical insurance. If I am an insured of Ping An Group and its partners, I will also authorize that Ping An Group and its partners can require that relevant persons, medical institutions or other groups having or understanding my health and medical records and who have treated or will treat me disclose health and medical related information to Ping An Group and its partners. The above-mentioned information collected by Ping An Group and its partners can be used, stored, and disclosed to other authorized entities for the purpose of claim assessment and medical insurance. I have known that the direct billing service is an upfront payment limited to the covered medical expenses that occur in this visit. In case of medical expenses uncovered by the insurance liabilities, medical expenses exceeding the corresponding upper limits, medical expenses that shall be paid by me at certain co-pay ratio, or premiums in arrears that shall be deducted from the benefit payment, if they shall be borne by me yet the hospital has not collected them from me, I shall assume the cost. A photocopy of this authorization shall have the same force as the original.

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

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