MSH CHINA

Non-Direct Billing Claim Form - Part A Patient Information

非直付理赔申请书 – A 部分 就诊人信息

For a claim to be valid, the following two pages (Part A and B) must be completed and submitted to MSH CHINA ENTERPRISE SERVICES CO., LTD. (hereinafter "Service Center") which is the appointed Service Provider appointed by your insurance company within 180 days after the date of service.Please full fill all parts with *, if patient is new born baby, Information related to ID document can be primary insured's.

为确保有效理赔，A与B两部分内容必须填写完整，并在从治疗之日后的180天之内向为您承保的保险公司指定的医疗保险服务机构万欣和（上海）企业服务有限公司（以下简称"服务中心"）提出理赔申请。以下信息标*号为必填项，填写证件信息时，如就诊人为新生儿，可以填写主被保险人信息。

Patient Information 就诊人信息	
Member ID 会员号*:	**DOB 生日*: MM月/ DD日/ YY年**
Name 姓名*:	**Gender 性别*: ☐ 男Male ☐女Female**
Nationality 国籍*:	**Profession 职业*:**
Type of ID document 证件类型*： ☐ Chinese ID card身份证 ☐ Passport护照 ☐Mainland Travel Permit for Hong Kong and Macao Residents 港澳居民来往内地通行证	
Number of ID document 证件号码*:	
Period of validity of ID document 证件有效期*: MM月/ DD日/ YY年- MM月/ DD日/ YY年	
Tel. 电话*:	Email 电子邮箱:
Permanent Address 常住地址*:	
Relationship between the Patient and the Primary Insured 就诊人与主被保险人的关系 ☐ Principal 本人 ☐ Spouse 配偶 ☐ Children 子女	

2. Payment Information 银行转账信息 (Please complete clearly, otherwise your non-network payment will be delayed.) （请务必清楚填写,否则您的个人理赔赔付会被延误。）	
☐CNY bank account(Mainland China) 人民币账户	
Account # 账号:	Name on the Account账户名:
Name of bank and branch开户银行:	
☐Non-CNY bank account(Out of Mainland China) 非人民币账户	
Account # 账号:	Name on the Account账户名:
Name of bank and branch开户银行:	
Swift Code/IBAN Number/ABA#/BSB:	
Preferred Currency（收款币种):	
Bank address(For Non-CNY account)银行地址:	
Please ensure the name on the invoice is the same as that on your ID/passport. 请确保您发票上的姓名与身份证或护照上的姓名一致。	

Anti- insurance Fraud Prompt 反保险欺诈提示：

Integrity is the fundamental principle of an insurance contract. If engaging in insurance fraud, one will undertake the following legal liabilities: 诚信是保险合同的基本原则，涉及保险欺诈将承担以下法律责任：

Criminal Liabilities: Whoever commits insurance fraud is subject to criminal liability and may be sentenced to criminal detention or fixed-term imprisonment, and shall also be fined or subject to confiscation of property. The appraiser and certifier of the insurance accident who intentionally provides false documents for another person to defraud shall be regarded as an accomplice in the crime of insurance fraud and punished as such.【刑事责任】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责任。 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。

Administrative Liabilities: If the insurance fraud activities can't constitute a crime, administrative penalties of 15 days of administrative detention or a fine of less than RMB 5,000, may still apply. The appraiser and certifier of the insurance accident who intentionally provides false documents for another person to defraud shall be regarded as an accomplice and is subject to the corresponding administrative penalties.【行政责任】进行保险诈骗活动，尚不构成犯罪的，可能会受到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。

Civil Liabilities: If one fails to fulfill the obligation of disclosure on purpose or due to gross negligence or there are other insurance fraud activities, the insurer/Service Center reserve the right to deny coverage of the related costs.【民事责任】故意或因重大过失未履行如实告知义务，或存在其他保险欺诈行为，保险公司/服务中心可能不承担赔偿或给付保险金的责任。

I hereby declare the information and all materials submitted by me are true and correct without false statements and gross omission. I have read and acknowledged the Anti-insurance Fraud Prompt. Insurer/Service Center is entitled to refuse to pay the insurance reimbursement and pursue the corresponding legal liabilities in case of false statement or concealment.本人声明上述填写内容，及本人提供的一切资料均完全属实，并无虚假或重大遗漏，且已阅读并知晓《反保险欺诈提示》，如有虚假或隐瞒情况，保险公司/服务中心有权拒付保险赔偿金并依法追究法律责任。

I authorize any physician, medical institution, druggist, insurance company, employer, labor union, organization, or individual to release information required for the claim audit to the Service Center (including third parties entrusted in writing by the Service Center). This includes my or my dependents' doctor notes, medical history, rescriptions, or treatment plans, including copies. I fully understand, in the absence of such information, the Service Center may not be able to process my and my dependents' claims, resulting in a partial coverage or rejection.All information collected during this process will only be used for health insurance coverage purposes, and will not be disclosed to any third party without my written consent. If this claim is a direct billing claim, I acknowledge I am responsible for any fees my insurance policy does not cover. A photocopy of this authorization shall be considered as effective and valid as the original.

为此理赔需要，为使我、我的附属被保险人完全得到应偿付的所有保险金，我授权任何医生、医疗机构、药剂师、保险公司、雇主、工会, 机构或个人将我、我的附属被保险人就医治疗、接受护理的相关病历、病史等资料信息（包括复印件）提供给服务中心（含服务中心采用书面形式授权委托的第三方公司）。我完全理解：无此等信息可能影响我及我的附属被保险人的保险理赔。而服务中心在无法获取此等信息情况下也可能无法处理我及我的附属被保险人的理赔及满足我及我的附属被保险人的的医疗需要。服务中心在此过程中收集的所有信息只用于健康保险的范围内，未经我的书面同意，不会披露给任何第三方。如此理赔如属于直接付费，我愿意承担此保险所不承担的所有费用。此授权的复印件与原件具有同等效力。

I agree to entrust MSH CHINA ENTERPRISE SERVICES CO., LTD to act as my agent for this claim. The authority of the agent is to process the claim application, receive the notice of claim decision, receive the payment, and sign it, this authorization is valid until the settlement of this claim.

我同意委托万欣和（上海）企业服务有限公司就本次理赔事宜作为我的代理人，代理权限为：办理理赔申请，受领理赔决定通知，受领给付款项并签字，授权有效时间为本次理赔结案为止。

Patient's Signature 就诊人签字:	**If the Patient is a minor, the Claimant shall sign the signature 若就诊人为未成年人，由申请人签字**
Date 日期: MM月/ DD日/ YY年	

MSH CHINA

Claim Form - Part B Medical Information
理赔申请书 – B 部分 医疗信息

In additional to filling the claim form A with Claimant's signature, you also need to provide below materials. 除了填写带就诊人签名的理赔表**A**面之外，你还需要提供以下材料：

- ✓ **A photocopy of the medical record(s) or discharge summary** 门诊病历, 住院提供出院小结复印件
- ✓ **Original tax invoice (Fapiao) or Original receipt(If the visit is occurred in Oversea)** 税务发票原件/（假如你的就诊发生在大陆以外）收据原件
- ✓ **Charge breakdown（Medicines、exams、treaments and other expenses) 收费明细（药费、检查费、治疗费和其他的费用)**
- ✓ **Herbs charge breakdown (Name, dosage and price of every herbs)** 中草药明细（每一种中草药的名称、数量/重量、价格）
- ✓ **Medical prescription** 药品处方
- ✓ **Photocopy of exam report** 检查报告复印件
- ✓ **A copy of your passport/ID card for RMB Payment 10,000 or all Non-RMB payment** 给付货币为人民币，索赔金额人民币**10,000**或以上或者给付货币为非人民币，需提供被保险人的身份证/护照复印件

Please note: A photocopy of the medical record(s) from the outpatient visit(s) may replace Part B of this Claim Form. Please submit discharge summary if it is an inpatient claim. 备注：门诊病历复印件可取代理赔申请书**B**面信息。住院理赔请提供出院小结。

3. Medical Information - To be Completed by the Treating Physician 医疗信息 – 由治疗医师填写

Chief Complaint and on what date (month/year) did you first notice the conditions or date of the symptoms appear? (Please describe the symptoms)? 主诉及该疾病第一次发现的时间或者相关症状

For conditions that have required long term treatments, please provide details of when the symptons and/or treatment began. 对于已经接受长期治疗的疾病，请提供症状和（或）治疗开始情况的详细信息

Physical Examination 体格检查:

Lab Tests and Exams 化验和检查:

Exam Results 检查结果:

Diagnosis/Impression 诊断/印象:

Details of treatment provided 治疗措施:

Please state name of drug(s) and dosage(s), otherwise your claim payment will be delayed. 请提供药品的名称和剂量，否则您的理赔赔付将会被延迟:

Signature of Treating Physician 治疗医生签名: Phone # 电话号码   Date 日期: MM月/ DD日/ YY年

Treatment is related to (Please check box if related to one of the following items) 本次治疗是否与以下相关（如是，请标出）:

- □ Maternity 产检或生产
- □ Immunization 注射疫苗
- □ Acupuncture 针灸 or Therapy 理疗
- □ Dental 牙科
- □ Checkup 体检
- □ Vision 视力

Date of Service 治疗日期	Description of Medical Procedure 医疗费用明细	Charges 收费
	Consultation fee(s) 诊疗费	
	Drug fee(s) 药费	
	Lab test fee(s) 实验室化验费	
	Exam fee(s) 检查费	
	Acupuncture fee(s)针灸费	
	Therapy fee(s) 理疗费	
	Others 其他	
	Total 总计	

理赔资料请寄送至个人理赔部
Please submit Claims to Non-Direct Billing Claim Department
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