

Crisis Cover / Intensive Care Bene it Claim Form

危疾理賠 / 深切治療保障申請書

Policy Number 保單號碼 :

Applicable to the specific insurance plans/product with Intensive Care Benefit Only (e.g. PRUHealth Critical Illness Extended Care III, PRUHealth Critical Illness First Protect II) 只適用於指定附有深切治療保障之保障計劃 (如「危疾加護保 III」,「危疾首護保 II」)

Intensive Care Benefit Life Assured admitted to Intensive Care Unit (ICU) for 3 or more consecutive days due to accident or illness 深切治療保障 受保人因意外或疾病入住深切治療病房 (ICU) 連續三日或以上

Part II – Medical Certification (to be completed by the Attending Physician, duly qualified and registered, at the claimant's expense) 第二部分 — 醫療報告 (由索償人自費聘請主診註冊西醫填寫)

Patient Details 病人資料

1. Name of Patient 病人姓名		2. Identity Document Number 身份證明文件號碼	
3. Age 年齡		4. Sex 性別	
5. Present smoking / drinking status 現在的吸煙/飲酒習慣	<input type="checkbox"/> Never 從無 <input type="checkbox"/> Not quitted 未停止 <input type="checkbox"/> Quitted, since 已於右述日期起停止 _____ / _____ / _____ Day日 Month月 Year年		
6. Are you the patient's usual physician? 你是否病人慣常求診之醫生?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, medical records traceable to 是, 醫療紀錄可追溯至 _____ / _____ / _____ Day日 Month月 Year年		

Hospitalization Details 住院詳情

7. Date of Admission 入院日期	_____ / _____ / _____ Day日 Month月 Year年	8. Date of Discharge 出院日期	_____ / _____ / _____ Day日 Month月 Year年
9. Name of Hospital 醫院名稱			
10a. Had the patient confined in Intensive Care Unit? 病人有否入住深切治療部?	<input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有		
10b. Please provide the treatment details during the ICU stay 請提供入住深切治療病房期間的治療詳情	Was the ICU stay for 3 or more consecutive days? 是否連續三日或以上入住深切治療部? <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes, please provide the period of ICU stay 是, 請提供入住深切治療病房時段 From 由 To 至 _____ / _____ / _____ _____ / _____ / _____ Day日 Month月 Year年 Day日 Month月 Year年 <input type="checkbox"/> AM 上午/ <input type="checkbox"/> AM 上午/ <input type="checkbox"/> PM 下午 _____:_____ <input type="checkbox"/> PM 下午 _____:_____ Time 時間 Time 時間		
11. Any home leave taken by the patient during the said hospitalization period? 病人在上述住院期間有否請假離院?	<input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes, please provide information on the right 有, 請提供右方所需資料	Date and Time 日期及時間	From 由 To 至 _____ / _____ / _____ _____ / _____ / _____ Day日 Month月 Year年 Day日 Month月 Year年 <input type="checkbox"/> AM 上午/ <input type="checkbox"/> AM 上午/ <input type="checkbox"/> PM 下午 _____:_____ <input type="checkbox"/> PM 下午 _____:_____ Time 時間 Time 時間
		Reason 原因	

Consultation Details 診治資料

12. Date on which the patient FIRST consulted you for this illness or injury 有關是次病症或受傷, 病人首次向閣下求診的日期	_____ / _____ / _____ Day日 Month月 Year年
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Consultation Details (Continued) 診治資料 (續)			
13a. Date of First consultation for illness or injury leading to ICU admission 有關是次病症或受傷而導致入住深切治療部首次求診日期	_____ / _____ / _____ Day日 / Month月 / Year年		
13b. Sign and symptoms complained of at the FIRST consultation 首次求診時出現的徵狀			
13c. Cause of Consultation 求診原因	<input type="checkbox"/> Accident 意外 Date of accident 意外日期 _____ / _____ / _____ Day日 / Month月 / Year年 Time of Accident 意外時間 <input type="checkbox"/> AM 上午 / _____ : _____ <input type="checkbox"/> PM 下午 _____ : _____ Time 時間	<input type="checkbox"/> Illness 病症 How long had the patient been experiencing these sign and symptoms BEFORE the first consultation? 首次求診前其徵狀已存在多久? _____ Day(s)日 _____ Month(s)月 _____ Year(s)年 Or since 或自 _____ / _____ / _____ Day日 / Month月 / Year年	
14. For this episode, had the patient previously seen other physician(s) for these symptoms? 就此次病症而言，病人之前有否就有關之病況向其他醫生求診？	<input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes, please provide information on the right 有，請提供右方所需資料 <input type="checkbox"/> 是否由其他醫院的醫生/專科醫生轉介，請提供右方轉介醫生資料	Name of Physician 醫生名稱	
		Address of Physician 醫生地址	
		Date 日期	_____ / _____ / _____ Day日 / Month月 / Year年
		Please provide the reason for referral to ICU 請提供轉介ICU的主要原因	
15. Please state the recommended diagnostic tests and the reason for the tests during this hospitalization. 請註明是次住院所建議的診斷性檢查之名稱及原因			
16. Can this type of treatment / test be managed on daycare or out-patient basis? 此次病症之治療/檢查是否可於日間中心或門診內進行？	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Please provide information on the right 請提供右方所需資料	Please provide reason 請提供原因	
Final Diagnosis Details 最後診斷之資料			
17. Final Diagnosis 最後診斷		18. ICD 9 Code 國際疾病分類編碼 (ICD-9)	
a)			
b)			
c)			
19. What is / are the underlying cause(s) for final diagnosis? 引起上述最後診斷的病因			
20. Was surgery performed? 有否進行手術？	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide information on the right 有，請提供右方所需資料	Surgery Date 手術日期	_____ / _____ / _____ Day日 / Month月 / Year年
		Surgery Name 手術名稱	
		Surgeon Name 外科醫生名稱	



Final Diagnosis Details (Continued) 最後診斷之資料 (續)

21. Summary of medical treatment given and tests performed with results.
總結有關治療及檢驗結果

Remarks: Please attach copies of histopathology / endoscopic / diagnostic / laboratory test report / operation summary, etc..
註：請連同病理檢驗/內窺鏡/診斷性化驗/檢驗報告/手術撮要等副本一併交回。

22. To the best of your knowledge, was the patient admitted to Intensive Care Unit (ICU) directly or indirectly due to or aggravated by the following:
根據閣下所知，病人是否因以下之原因，直接或間接由下列原因而入住深切治療部：

No 否 Yes, please tick where it is appropriate and give details
是，請在適當的位置劃上剔號及提供詳情

<input type="checkbox"/> Pregnancy / surrogacy, childbirth / termination of pregnancy 妊娠、代母身份、分娩或終止妊娠	<input type="checkbox"/> Mental disorder/ psychological or psychiatric conditions / behavioural problems/ personality disorder 精神紊亂、心理或精神疾病、行為問題或人格障礙
<input type="checkbox"/> War, hostilities, rebellion, riot 戰爭、戰鬥、叛亂、暴動	<input type="checkbox"/> Confinement primarily for physiotherapy or for the investigation of signs and/or symptoms with diagnostic imaging, laboratory investigation or other diagnostic procedures 任何只為物理治療或就檢查徵狀及/或病徵而進行之診斷影像、化驗室檢查或其他診斷程序的住院
<input type="checkbox"/> Criminal offence / attempted suicide/ self -inflicted injuries 參與任何刑事罪行或企圖自殺或蓄意自殘	<input type="checkbox"/> experimental and/or unconventional medical technology / procedure/ novel drugs / medicines 接受的醫療實驗及/或非主流醫療技術/程序/治療
<input type="checkbox"/> Cosmetic treatment not necessitated by injury caused by accident 除因意外受傷而必須進行的整容治療	<input type="checkbox"/> Treatment for obesity / morbid obesity/ weight control programmes/ bariatric surgery 治療過度肥胖、控制體重計劃或減肥外科手術
<input type="checkbox"/> Dental treatment/ surgery 牙科治療或外科手術	<input type="checkbox"/> Donor of all kinds of transplantations such as organs/ bone marrow transplantations 作為捐贈者的移植 (例如器官或骨髓移植)
<input type="checkbox"/> Scuba diving or engaging in or taking part in any kind of race other than on foot/ mountaineering 進行水肺潛水，或參加任何非徒步進行的比賽	<input type="checkbox"/> Treatment of sexually transmitted disease or sexual problems, gender issues or sex changes or gender re-assignments 由性接觸傳染的疾病或性問題，性別有關的問題或變性或性別重新分配
<input type="checkbox"/> Congenital / inherited condition 先天/遺傳性情況	<input type="checkbox"/> Alcohol / narcotics / drug abuse 飲用酒精飲料/毒品/濫用藥物
<input type="checkbox"/> Corrective aids or treatment of refractive errors 視力矯正	<input type="checkbox"/> Body check / vaccination & immunization injections 一般身體檢查/防疫注射
<input type="checkbox"/> Rehabilitation / convalescence 康復/療養	
<input type="checkbox"/> Others, please specify details: 如有其他，請說明詳情：	

23. Did you refer the patient to another physician or hospital? 你有否轉介病人予其他醫生或醫院？	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide information on the right 有，請提供右方所需資料	Name of the physician / hospital 醫生/醫院名稱	
		Address of the physician / hospital 醫生/醫院地址	
		Details for the referral reason 詳述轉介原因	

24. The prognosis of the condition 預計痊癒後的情況	<input type="checkbox"/> Good 良好 <input type="checkbox"/> Fair 一般 <input type="checkbox"/> Poor 甚差	25. Any possibility of having a relapse? 有否復發的可能？	<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有
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Medical History Details 病史詳情

26. Other than this episode, has the patient ever been treated for the same / related conditions?
除了此次病症，病人曾否患有同類/相關病況而接受治療？

No 否 Yes, please provide below information
有，請提供下列所需資料

Consultation Date (Day/Month/Year) 就診日期 (日/月/年)	Name of Physician / Hospital 醫生/醫院名稱	Diagnosis 診斷	Details of Treatment(s) / Hospitalization 診治/住院詳情



