PACIFIC CROSS INSURANCE

NOTIFICATION OF INPATIENT / OUTPATIENT CLAIM FORM

*Please complete the following **Sections A to C for Outpatient Claims** or **Sections A to D for Inpatient Claims** and attach this form with your claims. One form is required for each Insured Person (Patient).*

Please send all claims and inquiries to: **International Administrators Limited**
11/F, O.T.B. Building, 160 Gloucester Road, Wanchai, Hong Kong, SAR
Tel: (852) 2573 2535 Fax: (852) 2573 2917
E-mail: customerservice@pacificcross.com Website: http://www.pacificcross.com

A – PARTICULARS OF THE INSURED PERSON / PATIENT

Name of Policyholder		Policy No.
Name of Insured Person (Patient)		Member No.
Date of Birth (MM/DD/YY)	Sex	No. of Bill / Receipt / Statement
☐ Inpatient Claims	☐ Outpatient Claims	

B – STATEMENT BY THE INSURED PERSON / PATIENT (by parent if patient is a minor)

1. If as a result of an accident:
   (a) When and where did the accident occur?

   (b) Please state the occurrence of the incident:

   (c) Which part(s) of the body was injured?

2. If as a result of an illness, when did the symptom first appear?

3. Have you ever filed or are you going to file this claim under any other insurer? ☐ Yes ☐ No
   If "Yes", please provide claims settlement report.

C – AUTHORIZATION & DECLARATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility who has attended me to furnish to **PACIFIC CROSS INSURANCE COMPANY LIMITED** (or its representative) and permit the said insurance company (or its representative) to review any and all information requested with respect to any illness or accident, medical history, consultation, prescription or treatment and copies of all hospital or medical records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct.

I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

Date _____ *Signature of Patient (or parent if a minor)* _____

Please Turn Over

D – ATTENDING PHYSICIAN'S REPORT (to be completed by attending physician / surgeon only)

SECTION 1

(a) What was the exact diagnosis?
Date diagnosis was made ____/____/_____
(dd/mm/yyyy)

(b) If hospitalization was required, please state the diagnosis for which hospitalization was required.

(c) (i) When did the symptom first appear?

(ii) When did patient first consult you on this condition?

(iii) To the best of your knowledge, has the patient ever had a similar condition or symptoms or been hospitalized for the same condition or symptoms? If "Yes", please give dates and details:

(iv) To your knowledge, has the patient previously consulted any other doctors regarding these symptoms? If "Yes", please give names and address of the doctors:

(d) Was/were the symptom(s) a secondary condition of some other illness(es)? If "Yes", please give details:

(e) Was the condition caused by or in anyway associated with conditions mentioned below:

(i) Drug or Alcohol intake	Yes ☐	No ☐
(ii) AIDS	Yes ☐	No ☐
(iii) Infertility or sterilization	Yes ☐	No ☐
(iv) Cosmetic or plastic surgery	Yes ☐	No ☐
(v) Psychiatric and mental disorder	Yes ☐	No ☐
(vi) Congenital deformities or anomalies	Yes ☐	No ☐
(vii) Suicide, insanity or self-inflicted injury	Yes ☐	No ☐

(f) Did the patient's condition arise due to:

(i) Accident?	Yes ☐	No ☐
(ii) Illness or injury due to patient's employment?	Yes ☐	No ☐
(iii) Pregnancy?	Yes ☐	No ☐

If "Yes", state approximate date of commencement of pregnancy:

SECTION 2

(a) Admission date: Discharge date:

(b) Type of treatment given to the patient:

(c) For surgical or maternity claims:

(i) Name and nature of surgical or obstetrical procedure(s):

(ii) Date(s) of procedure(s):

(d) Discharge summary report:

SECTION 3

Is it possible to provide this treatment on an outpatient basis? If "Yes", please give reasons of performing this treatment on an inpatient basis.

Name of Attending Physician: _____

Address: _____

_____

_____

Telephone No.: _____

Email: _____

_____
Signature of Attending Physician with Stamp

Date: _____