

## NOTIFICATION OF INPATIENT / OUTPATIENT CLAIM FORM

*Please complete Sections A to D1 (a) 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: **Pacific Cross Insurance Company Limited**  
 c/o 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
<input type="checkbox"/> Inpatient Claims		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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Date

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Signature of Patient (or parent if a minor)

*Please Turn Over*

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

**Note: For Outpatient, only Section 1 (a) is required. This is applicable only if the diagnosis is not included in receipt, bill or prescription submitted along with the claim form.**

**SECTION 1**

(a) What was the diagnosis you have made to the conditions of the patient and when was it made?

(b) If confinement in a hospital was required, state diagnosis of condition in respect of 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 similar conditions or symptoms relating thereto or hospitalized for the same disorder? If “Yes”, please give dates and details:  
(iv) To your knowledge, had patient previously consulted any other doctors for these symptoms? If “Yes”, please give names and address of the doctors:

(d) Was the symptom a secondary condition to some other illness(es)? If “Yes”, please give details:

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

(i) The influence of drugs or alcohol intake?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ii) AIDS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iii) Infertility or sterilization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iv) Cosmetic or plastic surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(v) Psychiatric and mental disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vi) Congenital deformities or anomalies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vii) Suicide, insanity or self-inflicted injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

(f) Are any of the conditions treated due to:

(i) Accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ii) Illness or injury due to patient’s employment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iii) Pregnancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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: \_\_\_\_\_