Pre-Authorization Request Form

事先授权表

COMPLETION OF ALL FIELDS BELOW IS REQUIRED

提交事先授权，请协助完整地填写以下表格

If not a medical emergency as defined by your policy contract, you must wait until you have a written authorization from GBG Assist before proceeding with any procedure which requiring pre-authorization. Please see your policy for a list of those procedures, or visit www.gbg.com. Otherwise, penalty co-pay will apply to your claims, the risk of claim denial and the provider may decline to offer direct billing service.

若为合同条款定义的非急诊且需要事先授权的治疗，则需在收到 GBG 授权担保函后才可进行。您可以参照条款合同或在 GBG 网站 www.gbg.com 上查看需要事先授权的治疗列表。否则，被保人需要支付相应的处罚金，并且直付网络医院可能会拒绝提供直付服务，需要您做事后理赔，且存在理赔拒赔风险。

Section A. Patient information please write legibly
就诊人信息

Name (Last, First, MI) : 姓名:	Gender : 性别:
Date of Birth (MM/DD/YY) : 出生日期（月/日/年）：	GBG Membership ID: 保险会员号:
Contact Email: 邮箱:	Phone Number: 联系电话:

Diagnosis, Symptom, or Complaint (medical necessity for requested procedure):
医疗诊断，症状或主诉（申请治疗的必要性）：

Is the patient being admitted to the hospital overnight? If yes, expected number of days / duration:
是为就诊人申请住院治疗吗？（如果“是”请写明估计住院天数）： ☐ Yes 是 ☐ No 否
Inpatient days 住院天数:

Procedure or treatment name:
申请治疗项目的名称:

Expected date of surgery or inpatient admission: MM 月/ DD 日/ YYYY 年
预计手术治疗或住院日期:

Anticipated type of delivery (for maternity admissions only): ☐ Vaginal 顺产 ☐ Cesarean Section 剖腹产
预计分娩方式（仅因分娩住院填写）：

Section B. Physician information
医院信息

Hospital/Facility 医院/医疗机构名称:

Estimated cost:
预估费用:

Physician/Surgeon Name:
内科/外科医生姓名:

Date of the injury, illness, or accident first occurred: MM 月/ DD 日/ YYYY 年
初次受伤，生病，或意外发生的日期:
Describe how accident occurred if applicable:
如适用，请描述意外如何发生:

First consultation date for this condition: MM 月/ DD 日/ YYYY 年
疾病初诊日期:

Describe previous treatment(s) received for this condition, if any,
including dates (ex. medicines, consult, surgery, hospitalizations):
请描述曾因此问题而接受的任何治疗，例如药物、病史、手术、住院治疗详情和日期:

Physician/ Surgeon Name 主治医生/外科医生姓名:

Telephone Number:
电话:

Email:
邮箱地址:

PLEASE ATTACH ANY AVAILABLE INITIAL EXAM AND/ OR DIAGNOSTIC REPORTS TO SUPPORT THE MEDICAL NECESSITY OF THIS REQUEST.
请附上检查和/或诊断证明的原件以证明此申请治疗的必要

Section C. Signature of Physician 诊疗医师签名:

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.
任何人明知索赔材料中包含任何不实陈述或虚假信息，不完整或误导性信息的，皆为犯罪行为并会根据法律得到惩处，并可能受到民事处罚。

Member's Signature 会员签名： Date 递交日期： MM 月/ DD 日/ YYYY 年

If you have any inquires on the pre-authorization, please feel free to contact us through chinapreauth@gbg.com or the following hotline or WeChat online services.
若您对事先授权有任何疑问，您可以发邮件至 **chinapreauth@gbg.com**，拨打以下热线电话或联系我司微信平台进行查询。

Greater China: 86-400-816-9300 **U.S and Canada: 1-866-914-5333** **Rest of the world: 1-905-669-4920**
大中华地区： **86-400-816-9300** 美国和加拿大： **1-866-914-5333** 其他地区： **1-905-669-4920**