



Pre-Authorization Request Form

事先授权表

COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS AUTHORIZATION REQUEST. 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 requiring pre-authorization. Please see your policy for a list of those procedures, or visit www.yongcheng.com. Otherwise, penalty co-pay will apply to your claims, and the provider may decline to direct bill us.

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 Assist 授权担保函后方可进行。您可以参照条款合同或在 Alltrust 网站 www.yongcheng.com 上查询参考需要事先授权的治疗列表。否则, 被保险人需要支付相应的处罚金, 并且网络直付医院可能会拒绝提供直付服务, 需要您做事后理赔。

Section A. Patient information please write legibly 病人信息	
Name (Last, First, MI) : 姓名:	Alias: 别名:
Date of Birth (MM/DD/YY) : 出生日期 (月/日/年) :	Policy ID Number: 保险号码:
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 having surgery? 是为病人申请手术吗? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	
Is the patient being admitted to the hospital overnight? If yes, expected number of days / duration: <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是为病人申请住院治疗吗? (如果“是”请写明估计住院天数) :	
Procedure or treatment name: 申请治疗项目的名称:	
Expected date of surgery or inpatient admission (MM/DD/YY): 预计手术治疗或住院日期 (月/日/年) :	
Anticipated type of delivery (for maternity admissions only): <input type="checkbox"/> Vaginal 顺产 <input type="checkbox"/> Cesarean Section 剖腹产 预计分娩方式 (仅因分娩住院填写) :	
Estimated cost : 估计费用:	Currency : 货币:
Hospital/Facility : 医院/医疗机构名称:	Physician/Surgeon: 内科/外科医生姓名:
Hospital location: 医院地址:	Tax ID Number (USA Doctors Only): 税号 (仅美国医院) :
First date injury, illness, or accident occurred (MM/DD/YY) : 受伤, 生病, 或意外发生的日期 (月/日/年) : Describe how accident occurred if applicable : 如适用, 请描述意外如何发生:	
First date you ever received treatment this condition (MM/DD/YY): 您曾经因此问题第一次就诊的日期 (月/日/年) :	
Describe previous treatment(s) received for this condition, if any, including dates (ex. medicines, consult, surgery, hospitalizations): 请描述您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:	
Section B. Physician information 医生信息	
Physician/ Surgeon Name: 主治医生/外科医生姓名:	Tax ID Number (USA Doctors Only): 税号 (仅美国医院) :
Address : 地址:	
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性。	
Section C. Signature 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。	
Signature 签名 :	Date 递交日期 :

If you have any inquiries on the pre-authorization, please feel free to contact us through following hotline which you can find on the back side of your membership card.
 若您对事先授权有任何疑问, 请随时拨打以下热线进行咨询。您也可以在您的会员卡背面找到以下热线联系方式。

Greater China: 400-613-8901; +86 10 6552 5313
 大中华地区: 400-613-8901; +86 10 6552 5313

U.S and Canada: 1-866-914-5333
 美国和加拿大: 1-866-914-5333

Rest of the world: 1-905-669-4920
 其他地区: 1-905-669-4920