永诚财产保险股份有限公司
ALLTRUST INSURANCE COMPANY LIMITED

GBG
Insurance Without Borders℠

Pre-Authorization Request Form
事先授权表

COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS AUTHORIZATION REQUES. **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.gbg.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 授权担保函后才可进行。您可以参照条款合同或在 GBG 网站 www.gbg.com 上查参考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？ ☐ Yes 是 ☐ No 否

Is the patient being admitted to the hospital overnight? If yes, expected number of days / duration: ☐ Yes 是 ☐ 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): ☐ Vaginal 顺产 ☐ 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 inquires 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。

Mainland China: 400-816-9300 U.S and Canada: 1-866-914-5333 Rest of the world: 1-905-669-4920
中国大陆地区： 400-816-9300 **美国和加拿大：** 1-866-914-5333 **其他地区：** 1-905-669-4920