Quality HealthCare 卓健

NAVIGATOR Insurance Brokers Ltd.
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CignaLinks®

Hong Kong Claim Form

To be used for out-of-network medical claims under the CignaLinks® . . . Hong Kong programme.

SECTION A. Important Information: Please Read
Please complete and sign this claim form, and submit it along with itemised bills and receipts detailing the services rendered. Payment will be made to the employee only. Send your completed form, itemised bills, and receipts: By email at cignalinks@qhms.com By fax to (852) 2851-2845 By mail to QHMS Claims Department, Quality HealthCare Medical Services Limited 3/F, Skyline Tower, 39 Wang Kwong Road Kowloon Bay, Kowloon, Hong Kong Questions? Please contact QHMS By phone at (852) 8205-8205 By email at cignalinks@qhms.com

SECTION B. Employee and Patient Information (Please complete a separate claim form for each family member.)	
1.Employee's Name	2.Patient's Name
3.Employee's Date of Birth	4.Patient's Date of Birth
5.Daytime Telephone	6.Email Address
7.Cigna Member ID #	
8.Please indicate if you carry other health or travel insurance from which you may receive full or partial reimbursement. Name of Insurance Company Covered Amount (please provide supporting documents with breakdown of the covered amount)	

SECTION C. Payment Details

1.List of expenses for which reimbursement is claimed, the date of service, and the amount.

Diagnosis (reason for treatment)	Date of Service (earliest if multiple)	Amount (HK Dollars)

Section C continued . . .

SECTION C. (continued)		
2.Select payment method	Cheque ☐	Bank Transfer ☐
*Cheques will be issued to the policy holder (staff member) and mailed to your primary mailing address. Please contact QHMS to make sure that this address is current if you have recently relocated.		
3.If payment is to be sent to your bank account, please complete the following.		
Name of Account Holder (must be exact)		
Bank Account #	Bank Name	
Sort/Swift/ABA – Routing Code		
Bank Branch Address		
Name of Insurance Company		
Currency of Account† † Please note: Reimbursement for claims made on this form will be in Hong Kong Dollars only.		

Fraud Notice:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer, fi les a statement of claim containing false,incomplete, or misleading information commits a fraudulent insurance act, which is a crime.

Patient's Signature and Release (parent or guardian, if claim is for a minor):
I certify that the information supplied is true and correct. I authorise the release of all records or other information which may be necessary to determine benefi ts payable. The information provided on this form may be used and disclosed to other persons orentities, including my Plan Sponsor, for the purpose of processing of this claim and performing health plan administration.

Patient's Signature _____ Date _____

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Global Health Benefits