Blue Cross 藍十字
Member of BEA Group 東亞銀行集團成員

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DENTAL TREATMENT CLAIM FORM 牙科治療索償申請表

You can now submit your claims to Blue Cross via the 24/7 EasyClaims platform on Blue Cross HK App or Super Care website within 90 days from dental treatment completion date. The approval process can be completed in 3 working days, which greatly shortens the processing time of claim application submitted by mail or in person.
您現可於完成牙科治療後 90 天內透過 Blue Cross HK App 或 Super Care 網站內 24/7 運作的「索償易」平台向藍十字提交索償申請，最快 3 個工作天完成批核，大大縮短以郵寄或親身遞交索償申請的時間。

Download now
立即下載

Blue Cross HK App

Enjoy Speedy 3-Step Dental Treatment Claim Submission via EasyClaim
(Applicable to dental treatment claim amount of each receipt is HK$3,000 or below)
1. Input claim details
2. Upload the scanned copies/photos of receipt
3. Confirm

透過「索償易」享用快速簡單 3 步遞交牙科治療索償申請
（只適用於每張收據不超過 HK$3,000 之牙科治療索償）
1. 輸入索償資料
2. 上載收據之掃瞄副本／相片
3. 確認

Claim Notes

1. This form is applicable to dental treatment claim. **Each claim form is for one Insured only**.
2. You can find the Policy number and Insured number on Blue Cross Certificate of Insurance or Blue Cross Healthcare Card, you may also visit www.bluecross.com.hk/supercare to view account information after logging in.
3. Please print this claim form on A4 size paper and send it together with the original receipts to Medical Claims Department of Blue Cross (Asia-Pacific) Insurance Limited ("The Company") within 90 days from dental treatment completion date. The Company's Personal Information Collection Statement as accompanied with this form is for your reference and retention, please do not return it along with your claim application.
4. The Company is entitled to request for your provision of further information and documents or completion of other specific claim forms.

Claim Instructions

1. Attach the **original** receipts issued by the dentist or certified true copy of receipts issued by other insurers (if applicable). Each receipt **MUST** state the following information:
   - Full name of patient/insured
   - Date of treatment
   - Breakdown of charges
   - Dentist's signature and official stamp
2. Complete and sign this form.
3. Provide copy of claim settlement advice from other insurers, if applicable.
4. Original receipt will not be returned once submitted. Please tick the appropriate box if certified true copy of receipt is required.

索償注意事項

1. 此申請表適用於牙科治療索償。**每名受保人須獨立填寫申請表**。
2. 您可於藍十字保險證明書或藍十字醫療卡上查看保單號碼及受保人號碼，您亦可登入 www.bluecross.com.hk/supercare 查閱帳戶資料。
3. 請以 A4 紙打印此索償申請表，並於完成牙科治療後 90 天內，連同收據正本一併交回藍十字 (亞太) 保險有限公司 (「本公司」) 醫療保險理賠部。隨本申請表附上的收集個人資料聲明，是供閣下參閱及保留之用，請無需於提交索償申請時退回。
4. 本公司有權要求閣下提供更多資料及文件或填寫其他專用索償表格。

索償申請指示

1. 附上由牙科醫生簽發的收據**正本**或由其他保險公司發出的收據核實副本 (如適用)。每張收據**必須**列明以下資料：
   - 病人／受保人姓名
   - 治療日期
   - 收費項目說明
   - 牙科醫生簽署及蓋章
2. 填妥此申請表及簽署。
3. 如適用，請提供其他保險公司之賠償結算通知書副本。
4. 一經遞交之收據正本將不獲發還。如需索取收據之核實副本，請於適當空格內畫上「✓」號。

Part I 甲部 – To be completed by the Insured (Patient) 由受保人 (病人) 填寫 – Part 1/2 部分

(or his/her parent if the Insured is aged below 18 若受保人之年齡在 18 歲以下，請由其家長填寫)

To avoid delay in processing your claim due to incomplete information, please complete all the below information in English BLOCK letters.
為免因資料不全而延遲處理閣下之索償申請，請以英文正楷填妥下列所有資料。

Name of Policyholder/Employer 保單持有人姓名 / 僱主名稱	Policy No. 保單號碼	Staff No. (if applicable) 職員編號 (如適用)
Name of Employee in English (if applicable) 僱員之英文姓名 (如適用)	Employee's Insured No. (if applicable) 僱員之受保人號碼 (如適用) |____|____|____|____|	HKID Card No. 香港身份證號碼
Name of Insured (Patient) in English 受保人 (病人) 之英文姓名	Patient's Insured No. (must be provided) 病人之受保人號碼 (必須提供) |____|____|____|____| - |____|____|____|	HKID Card No. 香港身份證號碼

☐ Original receipt will not be returned once submitted. Please put a "✓" in this box for request of certified true copy of receipt for other insurance claims.
一經遞交之收據正本將不獲發還。如需索取收據之核實副本辦理其他保險索償，請於方格內畫上「✓」號。

Declaration and Authorisation 聲明及授權書

1. I/We have obtained all necessary authorisation from my/our dependents (if applicable) to supply their information to Blue Cross (Asia-Pacific) Insurance Limited ("the Company") or its authorised representative if my/our dependents are parties to the claim request(s). I/We also understand that the information requested in this form is required in order for the Company to process these claims.
2. I/We hereby authorise any hospital, physician, medical practitioner, medically related service provider, insurance company, person, party and/or authority that has any records or is holding any information of the insured person or me/us to disclose to the Company or its authorised representative, any and all information with respect to the insured person's or my/our loss, disability, claim history, medical history, police statement made and the like for the purpose of assessing the insured person's or my/our claim request(s). A photocopy of this authorisation shall have the same effect as the original.
3. I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.
4. I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.
5. I/we agree and understand that the claims' information (including but not limited to submitted medical records) may be disclosed to the Employee's Insured.

1. 如本人 / 我們之家屬為賠償申請之一方，本人 / 我們已向家屬取得一切所需授權 (如適用)，向藍十字 (亞太) 保險有限公司 (「貴公司」) 或其授權代表提供其個人資料，本人 / 我們亦明白本表內所提供的資料是讓貴公司作處理本人 / 我們索償之用。
2. 本人 / 我們謹此授權任何持有受保人或本人 / 我們之任何記錄或資料的醫院、醫生、醫學界執業人士、與醫療有關的服務供應商、保險公司、有關人士、機構、及 / 或有關當局，向貴公司或其授權代表提供任何或所有有關受保人或本人 / 我們之損失、損傷、賠償記錄、病歷、口供或任何相關資料作評估受保人或本人 / 我們的賠償申請之用途。此授權書之正本及副本皆具同等效力。
3. 本人 / 我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此賠償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人 / 我們明白發出或填妥此賠償表格並不代表貴公司確認責任或保證賠償。
4. 本人 / 我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。
5. 本人 / 我們同意並理解，索償的資料 (包括但不限於已提交的醫療記錄) 可能會提供給僱員之受保人。

_____ _____

Signature of Insured (Patient) 受保人 (病人) 簽署 Date 日期 (DD/MM/YY 日 / 月 / 年)

In the event of the Insured aged below 18, this form should be signed by his/her parent. 倘若受保人之年齡在 18 歲以下，本申請表須由其家長簽署。

Part I 甲部 – To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 2/2 部分

Total Number of Receipt(s) 收據總數	Total Amount of all Receipt(s) (please specify currency) 收據總額（請列明貨幣）
Name of Dentist 牙科醫生姓名	Date of Treatment 治療日期 （DD/MM/YY 日 / 月 / 年） From 由 _____ To 至 _____

Was the dental treatment a result of an accident? 此次牙科治療是否由於一宗意外引致？ ☐ Yes 是 ☐ No 否

Date 日期（DD/MM/YY 日 / 月 / 年）_____ Time 時間 _____ Place 地點 _____

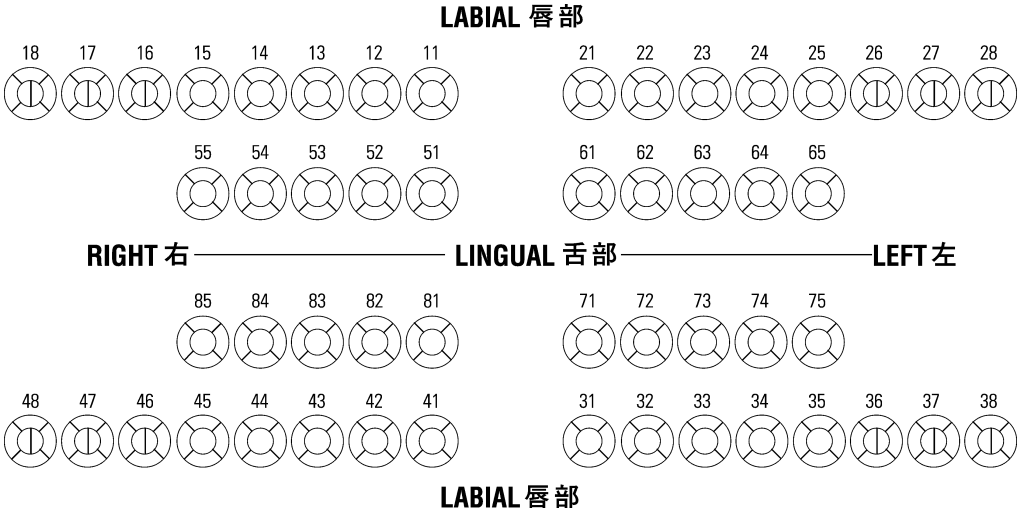
Brief Description 經過 _____

Part II – To be completed by the attending dentist at the claimant's own expenses
乙部 – 由主診牙科醫生填寫，所需費用由索償人自行承擔

Full Name of Patient (please fill in English BLOCK letters) :
病人全名（請以英文正楷填寫）：_____

	Date (DD/MM/YY) 日期（日 / 月 / 年）	Treatment Details 治療詳情	Charges (please specify currency) 收費（請列明貨幣）
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		Total Amount 總額	

Please mark teeth treated or area of oral treatment on the following chart.
請在下圖表示接受治療之牙齒或口腔治療範圍。



Was the dental treatment a result of an accident? 此次牙科治療是否由於一宗意外引致？ ☐ Yes 是 ☐ No 否

Details 詳細說明 _____

Remarks 備註

I hereby certify that all information given above is accurate, true and complete and are given to the best of my knowledge.
本人謹此聲明，就本人所知，上述所提供的所有資料均是準確無誤、真實及為事實之全部。

Signature and official stamp of attending dentist 主診牙科醫生簽署及蓋章

Address and Telephone No. 地址及電話號碼

Name of attending dentist and qualifications 主診牙科醫生姓名及資歷

Date 日期（DD/MM/YY 日 / 月 / 年）