

Patient Name:	Policy / Member number:
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a p at the claimant's expense

Please "✓" check as appropriate

C1. Illness

C2. Accident / Injury

a. When did the symptoms first appear and initial diagnosis	a. Describe briefly the mechanism of the accident / injury, and give the final/provisional diagnosis
b. Final diagnosis and when was it made	b. Date of accident or injury
c. Date the patient first consulted you about these symptoms / condition	
d. Is this the first time the patient has experienced these symptoms or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (please give details below)	
e. Are you the first medical practitioner the patient has seen about these symptoms or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (please give details below)	
f. Has any procedure, service, or test been recommended but not completed? <input type="checkbox"/> Yes (please give details below) <input type="checkbox"/> No	

C3. Surgery (please provide operation notes & biopsy report(s), if any) C4. Pregnancy/fertility/sexual dysfunction

Date(s) of surgical procedure performed	Do these services relate to pregnancy? <input type="checkbox"/> Yes (please give details below incl. est. delivery date or LMP, and indicate if this pregnancy is the result of assisted conception or infertility treatment) <input type="checkbox"/> No
Name(s) of surgical procedure performed	Is this claim related to infertility or sexual dysfunction (including services intended to increase chances of conception or carrying pregnancy to term)? <input type="checkbox"/> Yes (please give details below) <input type="checkbox"/> No

PLEASE PROVIDE ALL INVESTIGATION / LABORATORY / PATHOLOGY REPORT(S) AND DISCHARGE SUMMARY, IF ANY

Space for additional details:

Attending Physician's particulars

Name of Attending Physician:	Telephone:	Fax:
Address:	Email:	

Signature and official stamp of Attending Physician

Date

Please send completed form to:

Arranged and administered by:

APRIL Hong Kong Limited
 9th Floor, Chinachem Hollywood Centre
 1-13 Hollywood Road, Central, Hong Kong
 Tel: +852 2526-0918 Fax: +852 2526 0769
 Email: claims.hk@april.com

- Have you completed Section A & B?
- Have you signed the Declaration and Authorisation for Release of information?
- Have you enclosed the original bills and receipts showing what services were rendered and the charge for each?
- If required, has your physician completed and signed Section C, and attached any laboratory, scan, or other reports?
- If you have other insurance, a copy of the explanation of benefits from that claim?