THE CHINESE UNIVERSITY OF HONG KONG
UNIVERSITY HEALTH SERVICE
香港中文大學保健處

FOR OFFICE USE
Ref No:
Date Received:

Staff Medical Benefits Scheme (SMBS) - Reimbursement Application
僱員醫療福利計劃 - 醫 療 款 項 退 還 申 請 表

1. Please provide complete and detailed information in this form.
2. Please attach the original and itemized receipts and bill(s) showing the date of consultation/service.
3. Application should be made within 90 days from the date of service. (90 days after delivery for obstetric case)
4. For reimbursement enquiry, please login CUPIS personal account.

1. 請填寫所有欄位，並確保資料準確。
2. 請附上正本收據（必需列明各分類收費及接受診治/服務日期）、單據及有關文件。
3. 請於接受治療或出院後九十天內向保健處呈交申請表。(產科於生產後九十天內)
4. 如欲查閱醫療退款資料，請登入中大人事訊息系統個人戶口。

SECTION A PERSONAL INFORMATION 甲部 - 個人資料

Patient Name 病人姓名:	Top-Up Medical Insurance Scheme Member 附加醫療保險計劃成員: ☐ Yes 是 ☐ No 否 Liberty International For enquiry, please call Liberty International Insurance Ltd at 2892 3809. 查詢有關計劃，請致電 2892 3809 與利寶國際保險有限公司聯絡。
Staff Name 職員姓名: *(If different from above 如與上不同)*	
Staff ID 職員証號碼 :	
Staff Department 職員部門:	Terms of Service 服務類別: ☐ Terms A 甲類 ☐ Terms B 乙類 ☐ Terms C 丙類
Staff Post 職員職位:	Staff Medical Benefits Scheme 僱員醫療福利計劃: ☐ 99 Scheme member 99 計劃僱員 ☐ Pre-99 Scheme member 99 前計劃僱員
Contact No 聯絡號碼:	
E-mail Address 電郵地址:	Employment Mode 受聘形式: ☐ Full-time 全職受聘 ☐ Fractional-time 部份時間形式受聘

SECTION B MEDICAL SERVICES 乙部 - 醫療服務

I. Diagnosis/Reason for Service: (e.g. gall stone, stomach pain, etc)
病症名稱/服務原因: (例: 膽石 、胃痛 等)

II. Referral Information 轉介資料

1. Referral by 轉介途徑: ☐ UHS Doctor 保健處醫生 ____________________ ☐ Accident and Emergency Department of Hospital Authority (HA) Hospitals 醫院管理局轄下公立醫院急症室
2. Date of Referral 轉介日期: _________________________
3. Specialty 專科:
   - ☐ Internal Medicine 內科 ☐ Surgery 外科 ☐ Psychiatry [Limitation] 精神科 [規限項目]
   - ☐ Gynaecology 婦科 ☐ Obstetrics 產科 ☐ Skin 皮膚科
   - ☐ Ophthalmology 眼科 ☐ Ear, Nose, Throat 耳鼻喉科 ☐ Paediatrics 兒科
   - ☐ Oncology 腫瘤科 ☐ Orthopaedics 骨科 ☐ Other 其他________________________________ (Please specify 請註明)
4. Name of Medical Consultant 專科醫生姓名: _________________________________

III. Other Information 其他資料:	IV. Total Charges 共銀: HK$

I authorize the medical information in relation to this claim to be used by the University Health Service, the Finance Office of the University and other relevant parties, e.g. the insurer, if necessary, for verification and reimbursement purpose. I declare the reimbursement of expenses under this claim received from other source, if any, have been reported herewith. I authorize the Finance Office to submit shortfall claim under SMBS (if any) on my behalf to Liberty International Insurance Limited.
本人同意將有關申請醫療款項退還手續所需之文件給予香港中文大學保健處、財務處、保險公司及其他有關單位(如有需要)作核實及處理醫療款項退還手續之用途。本人聲明在此已申報從其他途徑索償有關款項資料，並授權財務處遞交在「中大醫療計劃」有差額之申請給予利寶國際保險有限公司。

Applicant/Staff Signature 申請人/職員簽署: Date (dd/mm/yy) 日期 (日/月/年):

* Please tick, as appropriate 請於適當空格填上 "√"
(Oct 2021)

SMBS Enquiry hotline 醫療退款詢問熱線: 3943 4479/3943 6425/3943 6416