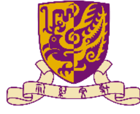

香港中文大學 大學醫務處
THE CHINESE UNIVERSITY OF HONG KONG
UNIVERSITY MEDICAL SERVICE OFFICE

FOR OFFICE USE
Ref No:
Date Received:

Staff Medical Benefits Scheme (SMBS) - Reimbursement Application Form
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 receipt(s) and bill(s) showing the date of consultation/service.
3. Please send the application to the Medical Benefits Administration Unit of the University Medical Service Office within 90 days from the date of treatment (For obstetric cases, within 90 days after delivery).
4. For reimbursement enquiry, please login CUPIS personal account.

1. 請於此申請表提供完整及詳細資料。
2. 請附上列明各項分類收費及接受診治/服務日期之正本收據及單據。
3. 請於接受治療或出院後九十天內 (產科於生產後九十天內) 向本處醫療福利組遞交申請文件。
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:
Staff Name 職員姓名: (If different from above 如與上不同)	☐ Yes 是 ☐ No 否 Liberty International
Staff ID 職員號碼:	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 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
Office Tel No 辦公室電話號碼:	
Mobile Tel No 手提電話號碼:	Employment Mode 受聘形式: ☐ Full-time 全職受聘 ☐ Fractional-time 部份時間形式受聘
Email Address 電郵地址:	

SECTION B - MEDICAL SERVICE 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: ☐ UMSO Doctor 大學醫務處醫生 ______________________ ☐ Accident & 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: ______________________

II. Other Information 其他資料:

IV. Total Charges 共銀: HK$

Declaration 聲明

I authorize the medical information concerning this claim to be used by the University Medical Service Office, the Finance Office of the Chinese University of Hong Kong, and other relevant parties, e.g. the insurer (if necessary), for verification and reimbursement purposes. I declare the information on the reimbursement of expenses under this claim received from other sources, if any, have been reported herewith. I authorize the Finance Office to apply for the shortfall claim under SMBS (if any) on my behalf to Liberty International Insurance Limited.
本人授權香港中文大學大學醫務處、財務處及其他有關單位，如保險公司 (如需要) ，使用與此退款申請相關的醫療資料，以供核實及退款之用。 本人聲明，從其他途徑索償有關款項之資料 (如有) 已在此申報。 本人授權財務處代表本人向利寶國際保險有限公司提交僱員醫療福利計劃下之差額索償申請 (如有)。

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 "√"

Enquiry Tel 查詢電話: 3943 4479 / 3943 6425 / 3943 6416