Cathay Pacific Airways Ltd Medical Claim Form

Please ensure that all sections of the claim form are fully completed, signed and **returned** to Quality HealthCare TPA Services Ltd. (QHTPA) **within 90 days of treatment date**.

Date of submission	For office use **RA**

PART A: PERSONAL PARTICULARS

Employee Name:	Employee ERN:
Patient Name:	Patient ERN:
Request a Certified True Copy of the original receipt for making second claim (will be sent to employee's corporate mailbox or office address) ☐ No ☐ Yes	Contact No.:

I hereby acknowledge the charges described herein, including all medications, tests and treatment ordered by the doctor during the consultation. I acknowledge that there may be fees and charges which may not be eligible for reimbursement under the medical plan, and, therefore, the amount I may receive in reimbursement may be less than the amount paid by me to the medical practitioner and/or hospital or clinic. These will include, but are not necessarily limited to, any charges which are in excess of my medical plan coverage or which are exclusion items under the medical plan as well as, should copay be a feature of my medical plan, copay charges incurred by me or my registered eligible dependants. I fully authorise my medical practitioner and/or hospital, or clinic, by whom or where I have been treated, to give full particulars including, if required for the purpose of assessing claims made under the medical plan (including assessing the validity and/or eligibility of such claims), prior medical history to QHTPA, Cathay Pacific Airways Ltd. (the "Company") or other agents as appointed by the Company. In line with Data Privacy requirements, I understand that any information provided to QHTPA, the Company or other agents as appointed by the Company shall only be used for the purposes of medical scheme administration and assessment of claims made under the medical plan. A copy of this signed declaration shall be as valid as the original.
Reimbursement will be credited into employee payroll bank account.

Employee's signature: **Date:**

PART B: CLAIM DETAILS

Nature of Expense ☐ Inpatient
☐ Outpatient (please specify) ☐ GP consultation ☐ SP consultation[1,2] ☐ Prescription[1]
☐ Physiotherapy[1] ☐ Investigation/imaging[1] ☐ Complementary Therapy

[1] Copy of doctor referral with diagnosis must be attached.
[2] **No referral required for Ophthalmologist, Orthopaedic Surgeon, Gynaecologist or Paediatrician.**

On Duty Travel ☐ Yes ☐ No	Work Injury related ☐ Yes ☐ No	Panel Doctor ☐ Yes ☐ No	Exceptional Approval Code (if any)

Date of Service / Admission	Country of service
Diagnosis	Total amount of this claim (please specify currency)

PART C: MEDICATION DETAILS (To be completed by attending doctor in English at claimant's own expense **ONLY IF** itemised details of service are not provided on the receipt.)

Name of Medication(s)	Dosage and Duration (days)	Price (specify currency)

PART D: TREATMENT DETAILS (To be completed by attending doctor in English at claimant's own expense **ONLY IF** itemised details of service are not provided on the receipt.)

Name of Treatments/ Procedures/ Investigation	Price (specify currency)

Name of attending doctor:	Address & Tel. No.:
Doctor's Signature and Clinic Chop:	Date:

Important notes:

1. You will need to file a claim in the following instances:
   a. Non-Panel Doctor/Physiotherapist/Medical Facility
   b. Complementary Therapies
   c. Overseas medical treatment*
   (*For overseas bills paid by credit card, QHTPA will follow the Company monthly exchange rate file to refund to employee. Please enclose a copy of the credit card statement if you wish to receive reimbursement of actual amount incurred in HK$.)

2. Please complete a new / separate claim form for:
   a. Each patient
   b. Each outpatient / inpatient / day case stay
   c. Each medical condition
   d. Each currency

3. Please ensure that **all sections** of the claim form are **fully completed**, signed and **returned within 90 days of treatment date**.

4. Always enclose the original invoices and receipts with itemised service details and the corresponding charges. Photocopies and credit card vouchers are not acceptable. Forms that are not fully completed may result in rejection of reimbursement.

5. Please return this form with the required documents as listed on point 9 to:
   a. Medical Claim Form collection box at 1/F Central Tower, Cathay City; or
   b. mail directly to Quality HealthCare TPA Services Ltd, CPA Claims Processing Centre, 3/F, Skyline Tower, 39 Wang Kwong Road, Kowloon Bay, Kowloon

6. Keep a copy of the Medical Claim Form and all claims document(s) for your records.

7. If additional information is required, QHTPA will send an email to your Company email address. All additional information **must be submitted within 30 days of the date of the email**.

8. Reimbursement will be credited into the employee's payroll bank account around 20 days after receipt of the completed Medical Claim Form and all necessary supporting documents. Please be advised that some fees and charges may not be eligible for reimbursement under the medical plan and therefore the amount you may receive in reimbursement may be less than the amount paid by you to the medical practitioner, hospital and/or clinic. Medical claim statement will be updated on the Member Portal.

9. Please be reminded that the following information **must be provided** in order for the claim to be processed:
   a. Name of patient, date of consultation
   b. Diagnosis – a doctor's receipt showing the diagnosis, completion of this form by attending doctor, or copy of hospital discharge summary showing the diagnosis
   c. Original receipts
   d. Itemisation of all charges on the receipts - name and charge of each of prescribed tests / medications/ treatments/ procedures. (If itemisation appears only on the invoices, please also submit these.)
   e. Please ensure that all information is printed and legible in **Chinese/ English.**
   f. Referral letter for specialist*/physiotherapy/ investigation done in laboratory or imaging centres.
   (*No such referral is required for Ophthalmologist, Orthopaedic Surgeon, Gynaecologist or Paediatrician).
   g. Copy of Prescription (for medication dispensed at a pharmacy)

10. For any enquiries contact QHTPA at 8200 7470 or via e-mail at cpa@qhms.com.