Bupa Hospital & Day Surgery Claim Form 保柏住院及日症手術賠償申請

47100096

Excluding Bupa Safe Critical Illness Insurance Scheme 保柏危疾全線保計劃除外

Please complete in BLOCK letters and preferably in English. Patient's membership number is MANDATORY and MUST be provided 請以英

Part I – To be Completed by Patient or Parent / Legal Guardian if Patient is below 18 years of age 第一部分 – 由病人填寫。如病人未滿18歲，須由家長 / 合法監護人填寫

Membership No. of Patient 病人會員編號 (16 digits 位 MANDATORY 必須提供)

6 0 9 9 2 9 3 6 - 0 7 1 1 2 1 1 3

Name of Employer (for group contract only) 僱主名稱 (只適用於團體合約)

Name of Subscriber / Employee (Surname followed by Given name, please leave a space between words) 投保人 / 僱員姓名 (先填姓氏，再寫名，每組字後請留一空格)

[redacted], Tang Tsz Shing

Name of Patient (If other than Subscriber / Employee)(Surname followed by Given name, please leave a space between words) 病人姓名 (如非投保人或僱員)(先填姓氏，再寫名，每組字後請留一空格)

Occupation (For Bupa Hospital cash scheme only)
職業 (只適用於保柏住院現金保障計劃)

Date of Hospitalisation / Day Case Surgery: From 住院 / 日症手術日期 由 10 / 09 / 25 (DD日 / MM月 / YY年) to 至 11 / 09 / 25 (DD日 / MM月 / YY年)

☐ Premium Waiver (For Bupa All Together Health Insurance Scheme)
保費豁免 (保柏家互通醫療保障計劃)

Mobile Number 流動電話號碼 852-94278238

If hospitalisation / treatment was due to illness 若因疾病而住院 / 治療

1. Describe symptoms leading to hospitalisation / treatment
請列出因何不適導致是次入院 / 治療: Chest Pain

Date when symptoms appeared 症狀出現日期: 16 / 08 / 25 (DD日 / MM月 / YY年)

2. Past medical consultation history – Name & address of
過往就診紀錄 – 有關醫生的姓名及地址:

a. Doctor who recommended this hospitalisation / treatment
建議是次入院 / 治療的醫生: Dr. Fung Wing Hong

First consultation date 初診日期: 18 / 08 / 25 (DD日 / MM月 / YY年)

b. Other attending doctor 其他主診醫生

First consultation date 初診日期: ___ / ___ / ___ (DD日 / MM月 / YY年)

c. Usual medical doctor 慣常就診醫生

First consultation date 初診日期: ___ / ___ / ___ (DD日 / MM月 / YY年)

If hospitalisation / treatment was due to accident 若因意外而住院 / 治療

3a. Please provide details of the accident 請提供意外詳情

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

b. How did it happen? 意外如何發生?

c. Injured area, type and severity of injury 受傷部位、類別及傷勢

d. Has the accident been reported to police? 意外是否已報警?
☐ Yes 是 (please provide a copy of the police report 請提供有關警察副本一份)
☐ No 否

4a. Have you filed this claim with another Bupa contract or any other insurer / organisation? (if yes, please specify below)
您是否已透過保柏其他合約或其他保險公司 / 組織提出索償? (如是，請列明如下) ☐ Yes 是 ☑ No 否

Type of compensation 索賠類型: ☐ Medical Expenses 醫療費用 ☐ Hospital Income 住院現金 ☐ Others 其他: ___

Name of Insurer 保險公司名稱: ___ Voucher no. (if claim in Bupa) 賠償申請表編號 (如從保柏索償): ___

Policy / Membership No. 保單 / 會員編號: ___ Reimbursement amount 索賠金額 HK$: ___

Please provide certified true copy of receipts (if original kept by other insurer) and claims statement advice
請提供核實副本收據 (如正本收據已交與其他保險公司) 及賠償結算通知書

b. Will you be filing this claim with another Bupa contract or any other insurer / organisation? (If yes, please specify below)
您是否將會透過保柏其他合約或其他保險公司組織提出索償? (如是，請列明如下) ☐ Yes 是 ☐ No 否

Name of Insurer 保險公司名稱: ___ Policy / Membership No. 保單 / 會員編號: ___

Declaration and Authorisation 聲明及授權書

I hereby declare that the above information given is true and correct. I also authorise any medical practitioner, hospital, clinic, by whom or where I / the Member have / has been observed or treated or any insurance company or organisation that has any records or health information concerning me and / or the Member for any reason, to give full particulars thereof including prior medical history to Bupa (Asia) Limited. A copy of this authorisation shall be considered as effective and valid as the original. I understand that if I and / or the Member fail to provide any information requested in this claim form, it may result in the inability of Bupa (Asia) Limited to accept or process the claim.
本人謹此聲明，以上所填報之一切資料，均屬真確無訛。本人並且授權任何為本人/會員觀察或治療的醫生、醫院、診所，或持有本人及/或會員健康或任何資料之保險公司或機構將本人及/或會員之全部資料 (包括病歷) 呈交予保柏 (亞洲) 有限公司。本授權書之副本與正本具有同等效力。本人明白，如本人及/或會員未能就本賠償申請表所需提供足夠資料，可能會導致保柏 (亞洲) 有限公司不能接受或處理本賠償申請。

Personal Information Collection Statement 個人資料收集聲明

I have read and understood the Personal Information Collection Statement ("Statement") included in this form. I have also brought the Statement to the attention of all relevant Insured Person(s) / Member(s) (or their guardians if applicable) and confirmed the understanding and agreement to it. I / We consent to the transfer of my / our personal data within or outside of Hong Kong for the purposes and to the types of transferees as set out in the Statement. I / We have understood the Statement's effect in respect of my / our personal information collected or held by Bupa (Asia) Limited, including the use, storage, processing, transfer, disclosure and / or sharing of part of or all of my / our personal information within the Group Companies in accordance with the Statement. The updated version of Statement is available for download from www.bupa.com.hk or Bupa's mobile applications. I understand that I have the right to request Bupa (Asia) limited to cease using my / the member's personal information for direct marketing purposes by emailing customercare@bupa.com.hk or calling the Customer Care helpdesk on 2517 5333.
本人已細閱並明白包含在本表格中的「個人資料收集聲明」。本人亦已促有關受保人/會員 (或其監護人，如適用) 留意「個人資料收集聲明」並確認明白及同意有關內容。本人/我們同意就「個人資料收集聲明」所述用途視乎情況提供本人/我們的個人資料至香港境內外予「個人資料收集聲明」所載的資料承讓人。本人/我們明白個人資料收集聲明對保柏 (亞洲) 有限公司收集或持有的本人/我們的個人資料的效力及影響，包括按照個人資料收集聲明使用、儲存、處理、轉移、公開或分享本人的部分或全部個人資料致任何集團公司之成員。該個人資料收集聲明最新的版本可於www.bupa.com.hk或保柏應用程式下載。本人明白本人有權透過聯絡保柏的客戶服務專線 (電郵至customercare@bupa.com.hk或致電2517 5333)，要求保柏停止將本人的個人資料用作直接市場推廣用途。

(MANDATORY 必須簽署)

X [redacted] Tang Tsz Shing
Signature of Patient / Parent or Legal Guardian (if Patient below 18 years of age)
病人簽署 / 家長或合法監護人簽署(適用於十八歲以下之病人)

X Tang Tsz Shing [redacted]
Name (in BLOCK letters)
姓名 (請以正楷英文書寫)

X Signed on 簽署之日期: 11 / 09 / 25 (DD日 / MM月 / YY年)

HKID Card No. / Passport No. (First 4 digit) 香港身份證 / 護照號碼 (首四位): G347

Remarks: before sending in this form, please read below Claims Submission Guidelines to expedite the process of your claim reimbursement. 備註：為加快處理閣下之賠償申請，請於交回此賠償申請表前先細閱下面之提交賠償申請指引。

OP/BCFH-HH/0625

Claims Submission Guidelines 提交賠償申請指引

Please tick against the below items submitted with this claim form. Please note that no reimbursement of claims shall be made for (1) Claims submitted after 90 days from the date of discharge / treatment, (2) Claims with missing / insufficient information.
請於提交賠償申請表時於下列項目加上✓號。請注意根據以下情況，賠償申請將不獲辦理 – (1)賠償申請表於治療日90天後遞交，(2)所需資料不足。

Document List 文件清單	Reminder on common missing information 通常遺漏的資料
☑ Claim form Part I (completed by patient) 申請表第一部分 (由病人填寫)	✓ Membership number 會員編號
☑ Claim form Part II (completed by doctor) 申請表第二部分 (由主診醫生填寫)	✓ Patient signature on Claim form Part I 病人於申請表第一部分簽署
☑ Full set of original receipts with invoices/statement of account 全套正本收據及發票 / 帳單	✓ Doctor has filled in Claim form Part II 醫生已填妥的申請表第二部分
☐ Certified true copy of receipts (if original kept by other insurer) and claims statement advice 核實副本收據 (如正本收據已交與其他保險公司) 及賠償結算通知書	✓ Doctor signature and chop on Claim form Part II 醫生簽署及蓋印於申請表第二部分
☐ Hospital Authority discharge summary / discharge slip with diagnosis, if any 醫院管理局發出的出院摘要 / 診斷結果出院紙 (如有)	✓ To claim the Emergency Out-patient Benefit for Accidents, please complete question (3) on Claim from Part I 如要索賠緊急意外門診保障，請填寫申請表第一部分問題 (3)
☐ Copies of all lab test/medical reports (for Cancer case, please provide all cancer related investigation reports, e.g. blood test reports, histopathological reports or molecular test reports, etc.) 化驗 / 檢驗報告副本 (對於癌症疾病，請提供所有與癌症相關的化驗報告，例如：血液檢查，組織病理學 或分子檢查報告等)	
☐ Pre-authorisation confirmation letter (if any) No. 初步保障審核確認信 (如有) 編號：_____	
☐ For Viral Wart/Benign Skin Lesion procedures, please provide the documents mentioned in Part II of question 7 "Viral Wart/Benign Skin Lesion" item (e) 對於病毒性疣/良性皮損程序，請提供第二部分問題 7 "病毒性疣/良性皮損" 中第(e)項的文件 Notice : All skin treatment without proven documents (e.g. histopathological report or photo) will be classified as skin lesion 注意事項：所有沒有證明文件（例如：組織病理學報告或照片）的皮膚治療將被歸類為皮損	

Is a certified true copy of the medical receipt(s) required to be returned? Please note: If your claims have been fully reimbursed, or if your claim was submitted online without physical original medical receipt(s) provided, no certified true copy will be issued. The physical original medical receipt(s) (if provided) will be retained by Bupa and will not be returned. Bupa reserves the right to reject or accept any request for certified true copy of medical receipt.
是否需要退回醫療費用收據的核實副本？請注意：如你已獲全額賠償，或你透過網上索償且未有提交醫療費用的收據正本，我們將不會發出收據的核實副本。保柏將保留醫療費用的收據正本(如提供)且不會退回。保柏保留權利接受或拒絕任何醫療費用收據的核實副本的申請。 ☑ Yes 是 ☐ No 否

Please send the completed form and supporting documents to Bupa (Asia) Limited - Claims Dept.
Address: 6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong
請將填妥之賠償申請表及相關文件交回「保柏 (亞洲) 有限公司 - 理賠部」
地址：香港九龍觀塘海濱道77號海濱匯第2座6樓

You can also submit claims online and track your claim status using myBupa features in Blua Health, our mobile app. Scan the QR code on the right to download Blua Health now!
你亦可透過我們的手機應用程式 Blua Health 內的 myBupa 功能遞交網上索償及查閱你的賠償進度。立即掃瞄右方的二維碼下載 Blua Health！

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Customer Care helpdesk:
客戶服務專線：

Bupa Members 保柏會員

Individual Scheme 個人計劃	(852) 2517 5333
Group Scheme 團體計劃	(852) 2517 5388
Bupa Gold 保柏尊貴寶	(852) 2517 5383
Global Prestige VHIS 環球優越自願醫保計劃	(852) 2517 5688

Bupa Members 保柏會員 (enrolled via HASE 透過恒生銀行投保)

Group Scheme 團體計劃	(852) 2517 5988
Essential/MyBasic VHIS 挚逸/保柏自願醫保	(852) 2517 5588
Excel/Excel Plus/Global Supreme/Global Prestige VHIS 挚尚/挚悅/挚卓/環球優越自願醫保計劃	(852) 2517 5688

Part II - To be Completed by Surgeon / Attending Physician 第二部分 - 由主診醫生填寫

Name of Patient 病人姓名: [redacted] Tang Tsz Shing

HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼:

Admission / Treatment Date 入院 / 治療日期: 10 (DD日) 9 (MM月) 25 (YY年)

Discharge Date 出院日期: 16 (DD日) 9 (MM月) 25 (YY年)

A. Clinical History 門診病歷

1. Patient's main symptoms / complaints during the first consultation 病人首次求診時的主要病徵 / 申訴

Chest Pain

2. Date of first consultation for this main symptoms / complaints 病人首次就此主要病徵或申訴的首次求診日期: 8 (DD日) 9 (MM月) 25 (YY年)

3. Patient suffered from the above symptoms / complaints for 病人於首次求診前上述的主要病徵或申訴已存在: 5 mon 8 7 25 days / weeks / months / years prior to the first consultation 日 / 週 / 月 / 年

B. Hospitalisation / Treatment History 住院 / 治療病歷

1. Date of medical procedure / treatment / diagnostic tests 接受手術 / 治療 / 診斷掃描日期: 10 (DD日) 9 (MM月) 25 (YY年)

2. Operation / procedure(s) performed 手術名稱 | CPT code 目前使用醫療服務術語代碼

Coronary Angiogram + IVUS + Percutaneous Coronary Intervention (PCI)	

3. Final diagnosis 最終診斷 | ICD code 國際疾病分類代碼

Coronary Artery Disease (CAD)	

Was the condition due to or associated with the following 上述情況是否因以下問題所致？

☐ Accidental bodily injury 身體意外受傷	☐ Abuse of drugs or alcohol 濫用藥物或酒精	☐ AIDS / HIV related illness, Venereal disease or Sexually Transmitted Disease 後天免疫力缺乏症(愛滋病) / 與人類免疫力缺損病毒(HIV)、性病或因性接觸感染之疾病
☐ Pregnancy, infertility or sterilisation 懷孕、不育或絕育	☐ Eyesight / Eye refraction 視力矯正 / 不正常	
☐ Mental illness 精神病	☐ Treatment for cosmetic purpose 美容治療	
☐ Developmental Condition 發育異常 / ☐ Congenital Condition 先天性症狀 / ☐ Hereditary Condition 遺傳性疾病		☐ Self-inflicted injury 蓄意自傷身體
☐ General check-up or vaccination 一般身體檢查或防疫注射		☐ NONE OF THE ABOVE 以上全部不是

4. (a) Please provide details of the hospitalisation and treatment that the patient underwent. 請提供是次住院及相關治療詳情。

Treatment 治療	Investigation 檢驗	Diagnostic tests 診斷掃描
PCI		

(b) Please provide details of the period of hospitalisation including reasons for number of days as in-patient. 請提供是次持續留院的日數及其原因。

CAD + PCI

(c) For other inpatient investigations/procedures/treatment (blood tests, imaging, other procedures), please provide the reason(s) for necessity, and why it was not done in an outpatient setting.
對於其他住院檢驗 / 程序 / 治療（驗血檢查、影像學或其他程序），請提供必要的原因，以及為什麼不在門診進行治療。

PCI

5. (a) Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were they medically necessary and recommended by you?
是次檢查、治療及住院日數(如有) 是否和上述診斷有直接關係而且是醫療所需及由醫生建議？ ☑ Yes 是 ☐ No 否

If "No", please give details. 如否，請詳述之。

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Part II - To be Completed by Surgeon / Attending Physician 第二部分 - 由主診醫生填寫

B. 5. (b) Could the surgery only be performed under general anaesthesia? 手術是否必須在全身麻醉下進行？ ☐ Yes 是 ☐ No 否

For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay. 如手術在監察麻醉下進行，請註明住院原因。

LA

(c) Please indicate the clinical risk(s) and medical reason(s) for hospitalisation. 請註明臨床風險及須留院的醫療原因：
Current health status (Co-morbidity) 現時健康狀況 (合併症)

Please specify 請明確說明：

PC

(d) Expected higher risk at operation 預期較高手術風險

Please specify 請明確說明：

NO

(e) Expected higher post-operative risk 預期較高手術後風險

Please specify 請明確說明：

NO

6. If the patient has consulted another physician during this hospitalisation, please provide the following 如病人於住院期間曾向另一位醫生求診，請提供以下資料：

Name of Physician 醫生姓名	Reason 原因	Treatment performed 治療詳情

7. Any other relevant clinical information in this case? 如是次治療尚有其他臨床資料，請提供。

Others 其他

If it is related to Cardiac Stent or Chemotherapy Regimen, please provide the following details. 如關於心臟支架或化療方案，請提供下列詳情。

Cardiac Stent 心臟支架

(a) Please provide the brand and model of the stent(s) that was/were used in the operation.
請提供手術所用支架的品牌名稱及型號。

Synergy / Orsiro

(b) What are the clinical benefits for using this specific type(s) of stent for this patient?
請闡述使用此種支架對這病人的臨床效益。

Appropriate size / length

(c) Any other factors that indicate the use of this stent type(s) over others in this case?
於是次病例中，有否其他原因顯示必須使用此種支架而不考慮用其他支架？

Appropriate size / length

Chemotherapy Regimen 化療方案

(a) Please provide the TNM (tumor-node-metastasis) staging of the current episode and any metastasis site(s) / relevant recurrent disease, if applicable. 請提供現階段腫瘤、淋巴結及轉移分期 (TNM Staging) 期數，以及轉移部位或相關復發性疾病，如適用。

(b) Is this curative or palliative?
目的是屬於治療性質還是緩解性質？ ☐ Curative 治療性質 ☐ Palliative 緩解性質

(c) Is this the first course/cycle of treatment?
這是否首次治療 / 首個療程 ☐ Yes 是 ☐ No 否

If No, any previous treatment course and reason for change? 如否，以前曾有過何種治療？為何需要改變療法？

(d) Any special considerations for using this treatment regimen in this patient? I.e. specific genetic markers, rare cancer, failed first line therapy, etc.?
為這病人使用此治療方案，有何特別考慮因素？即如特定遺傳標記、罕見癌症、首選治療方案失敗等。

Part II - To be Completed by Surgeon / Attending Physician 第二部分 - 由主診醫生填寫

B. 7. Any other relevant clinical information in this case? 如是次治療尚有其他臨床資料，請提供。

If it is related to Viral Wart / Benign Skin Lesion, please provide the following details. 如關於病毒性疣/良性皮損，請提供下列詳情。

Viral Wart/ Benign Skin Lesion
病毒性疣/
良性皮損

(a) Please specify the types, exact location, total number and size of the wart(s) / skin lesion(s).
請具體說明疣 / 皮膚損傷的種類、確切部位、總數及大小。

Types of wart(s) / skin lesion(s) 疣 / 皮膚損傷的種類	Exact location 確切部位	Number of wart(s) / skin lesion(s) 疣 / 皮膚損傷的數量	Size (mm/ cm) (please provide range of size if multiple) 大小(毫米或厘米)(如有多個，請提供尺寸範圍)	Presented sign and symptoms 出現的體徵和症狀

(b) Please elaborate if wart(s)/skin lesion(s) had any impact on member's activities of daily living (ADL): (If yes, please specify)
請詳細說明疣/皮膚損傷是否對會員的日常生活有任何影響：（如是，請說明） ☐ Yes 是 ☐ No 否

(c) Please outline the details of all the treatment including conservative treatments, member received so far
請概述會員目前接受的所有治療詳情，包括保守治療

Date of treatment 治療日期	Treatment 治療	Treatment progress 治療進展

(d) Please indicate whether the procedure was done in an Operating Theatre (or equivalent): ☐ Yes 是 ☐ No 否
請說明手術是否在手術室（或同等設施）進行：

(If yes, please specify the indication for use, and whether the facility fulfils the requirements as stipulated in the Code of Practice for Day Procedure Centres, regulation pursuant to the Private Healthcare Facilities Ordinance Chapter 633, Laws of Hong Kong)
如是，請說明使用在手術室(或同等設施)的原因以及該設施是否符合《日間醫療中心實務守則》或 根據香港法例第 633 章《私營醫療機構條例》制定的規例要求。

(e) Please provide the below documents to member for claim processing.
請向會員提供以下文件以進行索賠處理。

i. All treatment records from treatment centre which related to current wart(s) / skin lesion(s) operation
來自治療中心的與當前疣 / 皮膚損傷手術相關的所有治療記錄

ii. Operation record with details including time of operation duration, medication used, body parts with no. of wart(s) / skin lesion(s) with peration done
詳細的手術記錄：包括手術時間、使用的藥物、每個身體部位的疣 / 皮膚損傷的確切數量

iii. Clinical photos of the wart(s) / skin lesion(s) (before and/or after treatment) to determine the effectiveness (if any, with member's consent).
疣 / 皮膚損傷的臨床照片（治療前和/或治療後）以確定有效性（如有，並經會員同意）

iv. Pathology report (if any)
病理報告（如有）

v. Charges breakdown with details
收費明細及詳情

(f) Please specify any planning for further treatment and any more area is diagnosed with wart(s) / skin lesion(s)
請說明進一步治療的任何計劃和時程表，以及任何更多身體部位被診斷為疣/皮膚損傷。

If yes, please further elaborate the details and the clinical indication.
如是，請進一步詳細說明詳情和臨床指徵。

Part II - To be Completed by Surgeon / Attending Physician 第二部分 - 由主診醫生填寫

B. 8. Has the patient taken any home leave during this hospitalisation? 於住院期間，病人有否請假外出？ ☐ Yes 有 ☒ No 沒有
If "Yes", please state the date, time and reason 如有，請列明外出之日期、時間及原因：

9. (a) Is it an emergency case? 這是否緊急個案？ ☐ Yes 是 ☒ No 否 Arranged on 安排日期 DD日 MM月 YY年
If "Yes", please specify 如是，請明確說明：

(b) Is it an elective admission ? 這是否擇期入院 ☒ Yes 是 ☐ No 否 Arranged on 安排日期 DD日 MM月 YY年

10. Brief discharge summary 出院撮要

CBD XPU

11. Has the patient ever had the same or similar symptoms(s) before? 病人曾否患有同類病況？ ☐ Yes 有 ☒ No 無
If "Yes", what is the date of onset if known? 如有，何時為病發日期？ DD日 MM月 YY年

12. Had the patient been previously treated or hospitalised for this or any other disorders? 病人過去曾否就此疾病或其他病症而需接受診治或入院接受治療？
Please provide details if known. 如知悉，請提供詳情。

Dates 日期	Disease/Disorder/Complaint 疾病/失調/申訴	Details of treatment/hospitalisation 治療/住院的詳情	Name of doctor/hospital 西醫姓名/醫院名稱

(Please use any separate paper with the doctor's signature on it if more space is needed 若需另頁填寫，每張紙都須有醫生的簽署作實)

C. Others 其他

1. Are you the patient's treating doctor? 閣下是否病人的主診醫生？ ☒ Yes 是 ☐ No 否
If "No" please provide the referring doctor's contact details. 如否，請提供轉介醫生資料。

Name of Doctor 醫生姓名	Telephone No. 聯絡電話	Address 地址

Treating doctor's particulars 主診醫生資料

I hereby certify that I have personally examined the patient and attended to his/her illness or injury, and that the information about his/her current condition as stated above is true to the best of my knowledge and belief.
本人謹此證明，本人已親自對病人進行檢查並主診其疾病或傷病，以及據本人所知所信，以上所述有關病人的當前病況的資訊均為屬實。

Name of Doctor 醫生姓名	Telephone No. 聯絡電話	Email Address 電郵地址	Address 地址

Signature and Chop of treating doctor 主診醫生簽署及蓋章

X

Date 日期： DD日 MM月 YY年

Authorised Signature and Chop of Hospital 醫院授權簽署及蓋章

HONG KONG ADVENTIST HOSPITAL-STUBBS ROAD

Date 日期： DD日 MM月 YY年

Adventist 港 Hong Kong Adventist Hospital
Health 安 Stubbs Road

sicians Statement

Pl 735451 F 27/04/1957
[redacted] Tang Tsz Shing
[redacted] 鄧子成

Doctor Name: Boran Cheng
Doctor Code : _____
Room No: 52nd A
☐VIP ☐P ☐SP ☒Std ☐ICU ☐SCU

	Amount (HK$)
☐ **DFC — Consultation Fee** Date: _____	
☐ **DFS — In-Patient Care:** Date: From _____ To _____ Daily Rate: HK$ _____ Total No. of Day(s): _____	
☑ **DF — Doctor's Fee - Surgery / Procedure(s)** ☐ **DFA — Anesthetist Fee** Date: 10/8/19 Name of Operation / Procedure Abscess I&D c CBN	4000
☐ **DFCU — Miscellaneous / Consumables Sales** Name: _____	
Total:	4000

Diagnosis:

CBN

Physician's Signature

Important note: Hong Kong Adventist Hospital – SR is the billing agent for the above Physician. Should you have any questions regarding the above charges, please contact your Physician.

200-165
(20190905)

White – Patient, Yellow – PA, Blue – IPB, Pink – Physician copy

0310-C202509676

Adventist Health 港安 Hong Kong Adventist Hospital
Stubbs Road

735451 F 27/04/1957 ...ians Statement

Pleas... [redacted] Tang Tsz Shing
[redacted] 鄧子成

	Doctor Name: [illegible signature]
	Doctor Code : 1 6 [illegible]
	Room No: 8 2 1 [illegible]
	☐VIP ☐P ☐SP ☐Std ☐ICU ☐SCU

	Amount (HK$)
☐ **DFC** — **Consultation Fee** Date:	
☑ **DFS** — **In-Patient Care:** Date: From 10/9/25 To 11/9/25 Daily Rate: HK$ 2500 Total No. of Day(s): 2	5000
☑ **DF** — **Doctor's Fee - Surgery / Procedure(s)** ☐ **DFA** — **Anesthetist Fee** Date: 10/9/25 Name of Operation / Procedure Coronary Angio + [illegible] PCI	60000
☐ **DFCU** — **Miscellaneous / Consumables Sales** Name:	
Total:	65000

Diagnosis:

CAD

[signature]
Physician's Signature

Important note: Hong Kong Adventist Hospital – SR is the billing agent for the above Physician. Should you have any questions regarding the above charges, please contact your Physician.

200-165
(20190905)

White – Patient, Yellow – PA, Blue – IPB, Pink – Physician copy

0310-C202509676

Adventist 港
Health 安
Hong Kong Adventist Hospital · Stubbs Road
香港港安醫院·司徒拔道

HOSPITAL CHARGES SUMMARY 留院總結

Tang Tin Shing 鄧子成

Patient Name	病人姓名	[redacted]		Patient No.	病歷號碼	735454
Admission Date/Time	入院日期/時間	10 SEP 2025	10:56	Bed	床號	521A
Discharge Date/time	出院日期/時間	11 SEP 2025	12:49	Class	房類	STANDARD
Treatment Doctor	主診醫生	FUNG WING HONG, JEFFREY 馮永康				
Bill No.	單號	20252530106				

	HKD 港幣	HKD 港幣
Charges 費用		
Doctor Charges 醫生費用		
CHENG CHEUNG WAH, BORON 鄭長華		
DOCTOR PROCEDURE 醫生手術/程序費	40,000.00	
FUNG WING HONG, JEFFREY 馮永康		
DOCTOR PROCEDURE 醫生手術/程序費	60,000.00	
HOSPITAL INPATIENT CARE 醫生巡房費	5,000.00	
Sub Total of Doctor Charges:		105,000.00
Hospital Charges 醫院費用		
ACT MACHINE 心導管室儀器	330.00	
AUTO-INJECTOR KIT PACIFIC MED 自動注射器套件	1,110.00	
CC-PERCU.CORONARY INTERVENTION-PCI 冠狀動脈介入治療術	14,980.00	
CCIC BIOTRONIK CONSIGNMENT ORSIRO MISSION STENT X1, BALLOON X1 心導管室消耗品 BIOTRONIK	13,775.00	
CCIC BOSTON SCI CONSIGNMENT SYNERGY XD STENT X1, BALLOONX2, IVUS X1 心導管室消耗品 BOSTON	20,000.00	
CCIC ORBUSNEICH CONSIGNMENT BALLOONX1 心導管室消耗品 ORBUSNEICH	3,875.00	
CD / VIDEO TAPE 光碟 / 錄像帶	330.00	
CODONIC PAPER 記錄影像圖紙	220.00	
CONTRAST H/BRIX/VISIPAQUE 100CC 顯影劑 x 3	2,070.00	
CONTRAST ULTRAVIST 50CC 顯影劑	300.00	
CSR CONSUMABLES 消毒物料供應	253.00	
DC TERUMO OUTLOOK CATH TIGER 檢查導管	350.00	
DINAMAP	268.00	
GC MEDTRONIC 引導導管	1,760.00	
GW J&J .035/.038 X 260 導管鋼線	240.00	
GW TERUMO RUNTHROUGH 導管鋼線 x 3	6,510.00	
I-STAT 心導管室儀器	420.00	
I-STAT CARTIAGE 心導管室儀器	140.00	
IV CANNULATION/IV ASSET	639.00	
IV CARE PER DAY	191.00	
IVUS MACHINE 心導管室儀器	1,750.00	
MISC ABBOTT CO-PILOT 導管檢查消耗品	560.00	
MISC MEDTRONIC INDEFLATOR 導管檢查消耗品 x 2	1,800.00	
MISC TERUMO TR BAND 壓力止血帶	300.00	
NURSING PROCEDURE PER 15MIN	320.00	
OXIMETER READING PER TIME x 5	955.00	

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Health 安
Hong Kong Adventist Hospital · Stubbs Road
香港港安醫院·司徒拔道

STATEMENT OF ACCOUNT 留院賬單

Patient Name	病人姓名	Tang Tsz Shing 鄧子成 [redacted]		Patient No.	病歷號碼	735451
Admission Date/Time	入院日期/時間	10 SEP 2025	10:56	Bed	床號	521A
Discharge Date/time	出院日期/時間	11 SEP 2025	12:49	Class	房類	STANDARD
Treatment Doctor	主診醫生	FUNG WING HONG, JEFFREY 馮永康				
Bill No.	單號	20252530106				

Date 日期	Description 要項	HKD 港幣
10 SEP 2025	DOCTOR PROCEDURE 醫生手術/程序費	40,000.00
	DOCTOR PROCEDURE 醫生手術/程序費	60,000.00
	ACT MACHINE 心導管室儀器	330.00
	AUTO-INJECTOR KIT PACIFIC MED 自動注射器套件	1,110.00
	CC-PERCU.CORONARY INTERVENTION-PCI 冠狀動脈介入治療術	14,980.00
	CCIC BIOTRONIK CONSIGNMENT ORSIRO MISSION STENT X1, BALLOON X1 心導管室消耗	13,775.00
	CCIC BOSTON SCI CONSIGNMENT SYNERGY XD STENT X1, BALLOONX2, IVUS X1 心導管	20,000.00
	CCIC ORBUSNEICH CONSIGNMENT BALLOONX1 心導管室消耗品 ORBUSNEICH	3,875.00
	CD / VIDEO TAPE 光碟 / 錄像帶	330.00
	CODONIC PAPER 記錄影像圖紙	220.00
	CONTRAST H/BRIX/VISIPAQUE 100CC 顯影劑 X 3	2,070.00
	CONTRAST ULTRAVIST 50CC 顯影劑	300.00
	CSR CONSUMABLES 消毒物料供應	253.00
	DC TERUMO OUTLOOK CATH TIGER 檢查導管	350.00
	GC MEDTRONIC 引導導管	1,760.00
	GW J&J .035/.038 X 260 導管鋼線	240.00
	GW TERUMO RUNTHROUGH 導管鋼線 X 3	6,510.00
	I-STAT 心導管室儀器	420.00
	I-STAT CARTIAGE 心導管室儀器	140.00
	IVUS MACHINE 心導管室儀器	1,750.00
	MISC ABBOTT CO-PILOT 導管檢查消耗品	560.00
	MISC MEDTRONIC INDEFLATOR 導管檢查消耗品 X 2	1,800.00
	MISC TERUMO TR BAND 壓力止血帶	300.00
	PATIENT MEAL - DINNER 病人膳食 - 晚餐	108.00
	PCI CONSUMABLE PACK 冠狀動脈介入治療術消耗品套裝	3,950.00
	PHARMACY 藥房	296.00
	ROOM CHARGE - U500 五樓病房	900.00
	DINAMAP	268.00
	IV CANNULATION/IV ASSET	639.00
	IV CARE PER DAY	191.00
	NURSING PROCEDURE PER 15MIN	320.00
	OXIMETER READING PER TIME X 3	573.00
	SLENDER SHEATH 6F	660.00
	HKAH0001975415 CREDIT CARD(MASTERCARD)	-100,000.00
11 SEP 2025	HOSPITAL INPATIENT CARE 醫生巡房費	5,000.00
	PHARMACY 藥房	2,542.00
	OXIMETER READING PER TIME X 2	382.00

Important Note 重要事項: Please review this statement and notify us for any adjustment. Hospital reserves the right to bill any undercharges and refund excess.
Kindly retain this original statement for any adjustment. 此賬單如有任何錯漏，敬請通知本院並保留此正本以便辦理更正或退款手續。本院保留追回少收款或退還款項之權利。

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Adventist 港
Health 安
Hong Kong Adventist Hospital · Stubbs Road
香港港安醫院 · 司徒拔道

STATEMENT OF ACCOUNT 留院賬單

Patient Name	病人姓名	Tang Tsz Shing 鄧子成 [redacted]		Patient No.	病歷號碼	735451
Admission Date/Time	入院日期/時間	10 SEP 2025	10:56	Bed	床號	521A
Discharge Date/time	出院日期/時間	11 SEP 2025	12:49	Class	房類	STANDARD
Treatment Doctor	主診醫生	FUNG WING HONG, JEFFREY 馮永康				
Bill No.	單號	20252530106				

Date 日期	Description 要項	HKD 港幣
	HKAH0001975702 CREDIT CARD(MASTERCARD)	-86,902.00

Total Charges	總共費用:	186,902.00	Balance	結餘:	0.00
Total Refund	總共退款:	0.00			

Printed Date & Time: 11 SEP 2025 12:52:17

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Hong Kong Adventist Hospital · Stubbs Road
香港港安醫院·司徒拔道

OFFICIAL RECEIPT 收據

Patient Name	病人姓名	Tang Tat Sing 鄧子成 [redacted]		Patient No.	病歷號碼	735451
Admission Date/Time	入院日期/時間	10 SEP 2025	10:56	Bed	床號	521A
Discharge Date/time	出院日期/時間	11 SEP 2025	12:49	Class	房類	STANDARD
Treatment Doctor	主診醫生	FUNG WING HONG, JEFFREY 馮永康				
Bill No.	單號	20252530106				

Date 日期	Description 要項	HKD 港幣
10 SEP 2025	HKAH0001975415 CREDIT CARD(MASTERCARD)	-100,000.00
11 SEP 2025	HKAH0001975702 CREDIT CARD(MASTERCARD)	-86,902.00
	Total Receipts 收據總數:	-186,902.00

Printed Date & Time: 11 SEP 2025 12:52:18

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HOSPITAL CHARGES SUMMARY 留院總結

Patient Name	病人姓名	Tang Tsz Shing 鄧子成 [redacted]		Patient No.	病歷號碼	735451
Admission Date/Time	入院日期/時間	10 SEP 2025	10:56	Bed	床號	521A
Discharge Date/time	出院日期/時間	11 SEP 2025	12:49	Class	房類	STANDARD
Treatment Doctor	主診醫生	FUNG WING HONG, JEFFREY 馮永康				
Bill No.	單號	20252530106				

	HKD 港幣	HKD 港幣
PATIENT MEAL - DINNER 病人膳食 - 晚餐	108.00	
PCI CONSUMABLE PACK 冠狀動脈介入治療術消耗品套裝	3,950.00	
PHARMACY 藥房	2,838.00	
ROOM CHARGE - U500 五樓病房	900.00	
SLENDER SHEATH 6F	660.00	
Sub Total of Hospital Charges:		81,902.00
Total Charges:		186,902.00
Balance 結餘		186,902.00

Important Note 重要事項: Please review this statement and notify us for any adjustment. Hospital reserves the right to bill any undercharges and refund excess.
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Centre Medical
賢德醫療

中環皇打街1-3號中建大廈12樓1201室
SUITE 1201, 12/F, CENTRAL BUILDING, 1-3 PEDDER STREET, CENTRAL
TEL: 3481 6808 FAX: 2172 6369

Official Receipt

Transaction Code : 202508180015
Doctor : Dr. Fung Wing Hong, Jeffrey
Patient Code : Y007146

Date : 18 August, 2025

[redacted]
Tang Tsz Shing 鄧子成

Items	Qty.	Unit Fee	Dis. %	Net Fee	Amount
CONSULTATION	1	1800.00	0.00	1800.00	1800.00
MEDICATION	1	240.00	0.00	240.00	240.00
RESTING ECG	1	500.00	0.00	500.00	500.00

Total : 2540.00 Paid : 2540.00

Date	A/C	Paid Voucher No.
18 Aug, 2025	AMERICAN EXPRESS	2540.00

Diagnosis : Cad hyperlipidmeia

Drug Item	Qty.
LIPITOR 20MG	0
NUSTENDI 180 MG/10MG	0
ASPIRIN 80MG	30
FAMOTIDINE 40MG	30
LEVOTHYROXINE 100MCG (Thyroxine)	0
LEVOTHYROXINE 50MCG (Thyroxine)	0

馮永康醫生
Dr. Fung Wing Hong Jeffrey
Specialist in Cardiology 心臟科專科醫生
MD (CUHK) MBChB (CUHK) MRCP (UK) FHKCP
FHKAM (Medicine) FRCP (Lond) FRCP (Edin)
Suite 1201, 12/F Central Building,
1-3 Pedder Street, Central
T: +852 2172-6607 F: +852 2172-6369

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Centre Medical
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中環畢打街1-3號中建大廈12樓1201室
SUITE 1201, 12/F, CENTRAL BUILDING, 1-3 PEDDER STREET, CENTRAL
TEL: 3481 6808 FAX: 2172 6369

Official Receipt

Transaction Code : 202509060009
Doctor : Dr. Fung Wing Hong, Jeffrey
Patient Code : Y007146

Date : 06 September, 2025

[redacted]

Tang Tsz Sing 鄧子成

Items	Qty.	Unit Fee	Dis. %	Net Fee	Amount
CONSULTATION	1	1800.00	0.00	1800.00	1800.00
INVESTIGATION : BLOOD TEST (INNOVATIVE DIAGNOSTICS)	1	1870.00	0.00	1870.00	1870.00
MEDICATION	1	435.00	0.00	435.00	435.00
INJECTION	1	4500.00	33.33	3000.00	3000.00
Total :	8605.00		Net Total :		7105.00
			Paid :		7105.00

Date	A/C	Paid Voucher No.
06 Sep, 2025	VISA / MASTER	7105.00

Diagnosis : Cad hyperlipidemia

Drug Item	Qty.
ASPIRIN 80MG	30
FAMOTIDINE 40MG	30
LEVOTHYROXINE 100MCG (Thyroxine)	0
LEVOTHYROXINE 50MCG (Thyroxine)	0
PRALUENT 150MG	1
CLOPIDOGREL 75MG	30

馮永康醫生
Dr. Fung Wing Hong Jeffrey
Specialist in Cardiology 心臟科專科醫生
MD (CUHK) MBChB (CUHK) MRCP (UK) FHKCP
FHKAM (Medicine) FRCP (Lond) FRCP (Edin)
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Centre Medical
賢德醫療

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SUITE 1201, 12/F, CENTRAL BUILDING, 1-3 PEDDER STREET, CENTRAL
TEL: 3481 6808 FAX: 2172 6369

Official Receipt

Transaction Code : 202509170004
Doctor : Dr. Fung Wing Hong, Jeffrey
Patient Code : Y007146

Date : 17 September, 2025

[redacted]
Tang Tsz Sing 鄧子成

Items	Qty.	Unit Fee	Dis. %	Net Fee	Amount
CONSULTATION	1	1800.00	0.00	1800.00	1800.00
INJECTION	1	4500.00	33.33	3000.00	3000.00

Total : 6300.00 Net Total : 4800.00
Paid : 4800.00

Date	A/C	Paid Voucher No.
17 Sep, 2025	VISA / MASTER	4800.00

Diagnosis : Cad with recnet PCI

Drug Item	Qty.
ASPIRIN 80MG	0
FAMOTIDINE 40MG	0
LEVOTHYROXINE 100MCG (Thyroxine)	0
LEVOTHYROXINE 50MCG (Thyroxine)	0
PRALUENT 150MG	1
CLOPIDOGREL 75MG	0

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