保險業監管局
Insurance Authority

Understanding
Medical Insurance

Tips on Making Claims

保險業監管局 Insurance Authority
蓋世保鑑 Insurpedia
www.ia.org.hk
enquiry@ia.org.hk
3899 9983

In general, medical insurance provides compensation for an insured person on a reimbursement basis. To avoid unnecessary disputes, you should take note of the following points when making a claim.

1 Be aware of the deadline for lodging a claim

Medical insurance policies usually have a time limit for lodging a claim, normally within 30 to 90 days from the date of consultation or discharge from hospital. Insurers have the right to reject claims submitted after the deadline. Some insurers offer pre-authorisation services. This means that the insurer settles the pre-authorised bill directly with the medical organisation. You should apply for this service according to the time limit stated in the policy and prior to hospital admission.

The pre-authorised amount is only a preliminary assessment, and may be different from the final costs. The actual claim payment is subject to the final claims decision made by the insurer. If you are in doubt, please contact the relevant insurer directly.

2 Prepare the required documents

For reimbursement of relatively low medical costs, you are normally required to submit a claim form together with the official receipts and original copies of referral letters (if applicable). For hospital claims, the following documents are also normally required:

- A claim form completed and signed by the attending doctor and stamped by the hospital;
- Original hospital receipts;
- Copies of diagnostic or laboratory reports;
- A discharge summary and sick-leave certificate with diagnosis if hospitalised in a public hospital; and
- A copy of the police report, traffic accident report, or police statement if you were involved in a traffic accident.

If you plan to lodge a claim with more than one insurer, ask your attending doctor to complete the claim forms provided by the different insurers and get the hospital to stamp all the forms. After making the first claim, ask the insurer concerned to send you back the original receipts or certified true copies of the receipts, so that you can make a second claim.

3 Understand what "medically necessary" means

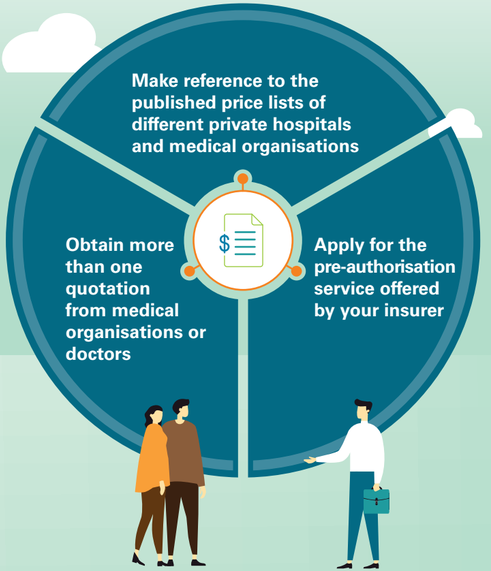
A referral by a doctor is not the sole factor constituting "medically necessary" as defined in a medical insurance policy. Insurers normally consider the following grounds when defining "medically necessary":

- Urgency of the condition?
- Urgency of the hospitalisation?
- Necessity for in-patient medication or surgery?
- Whether the hospitalisation is solely for diagnostic scanning and does not involve administering medication?
- Feasibility or difficulty of outpatient treatment?

In general, admission solely for conducting diagnostic or laboratory tests, when there is no element of medical emergency, will not be considered as being "medically necessary". To avoid unexpected out-of-pocket expenses, consult your insurer about the coverage and exclusions of your policy before any non-urgent hospitalisation.

4 Understand the "reasonable and customary" clause

"Reasonable and customary charges" is one of the principles insurers follow when handling claims. The insurer may not offer full reimbursement of the covered items if the claimable amount exceeds a "reasonable and customary charge", even if it does not exceed the annual policy limit. The insured person will have to pay the shortfall. To get a better estimate of likely out-of-pocket expenses, you are advised to assess the expenses in the following ways before accepting treatment:



» Tips on applying for insurance

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