GNP SEGUROS

Medical Report

Gastos Médicos / Health Insurance

Grupo Nacional Provincial, S.A.B. Av. Cerro de las Torres No. 395 Col. Campestre Churubusco C.P. 04200, CDMX. R.F.C. GNP9211244P0

Surgery Program and/or Medical Treatment and Reimursement

This form must be completed and signed by the **treating physician** in print.
Please do not leave questions or spaces unanswered. **This format will not be valid if it contains erasures or amendments**.

CLAIM

Please select the claim (or claims) the patient wants to file:

☐ Reimbursement ☐ Surgery scheduling ☐ Medication scheduling ☐ Service scheduling ☐ Indemnity ☐ Hospitalization

PATIENT INFORMATION

Policy Number	Patient Last name	Patient mother's Last name	Patient First name

Sex	Age	Reason for seeking medical care:
◯ F ◯ M		◯ Accident ◯ Ailment ◯ Pregnancy

MEDICAL HISTORY (SPECIFY TIME OF EVOLUTION)

The history must be provided regardless **of its relation** to the current diagnosis.
Please specify in each case the **onset dates** (dd/mm/yy)

Pathological history	Non-pathological history

Gynecology/obstetric history (anatomical description)	Perinatal history

Current medical condition According to the medical history and time of evolution of the disease, please specify the onset date (dd/mm/yy)

Medical condition date / /

Diagnosis / ICD

Date of diagnosis / /

Type of condition	Is there any relationship with other medical condition?	Specify which: (If there is no condition or ailment, please indicate "none")
☐ Congenital ☐ Acquired ☐ Acute ☐ Chronic	◯ Yes ◯ No	

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MEDICAL HISTORY (CONTINUATION)

Patient's vital signs and anthropometric measurements

Pulse	Breathing rate	Temperature	Blood pressure	Weight (lbs)	Height (ft.)

Physical examination results

Laboratory tests and other tests data (please attach confirmatory diagnostic tests reports)

(Specify the tests that were needed to confirm the diagnosis. If none were needed, please indicate "none"

Complications

Please describe the complications

Complications onset date

/ /

◯ Yes ◯ No

Treatment / CPT Detail the treatment plan (surgical / non-surgical), procedures and surgery technique, Please, specify in each instance the onset dates (dd/mm/yy)

Treatment date

/ /

List of materials used or that will be used during surgery and/or special equipment Specifing dates (dd/mm/yy)
Example: Laparoscopy equipment, fluoroscopy equipment

Comments

HOSPITAL OR CLINIC INFORMATION WHERE THE PATIENT WILL BE TREATED

Hospital, Clinic or Provider Name	City	State

Type of stay

◯ Emergency stay ◯ Long term inpatient hospitalization ◯ Short stay hospitalization

Inpatient date

/ /

PHYSICIAN OR SPECIALIST INFORMATION

Treating Physician

Last Name	Middle Name	First Name	Medical specialty

Board member ID	Specialty License Number	Office phone number	Mobile number

Email	Estimated Medical fees

Did you co-treat with other physicians or specialists?

◯ Yes ◯ No

CO-TREATING OR PARTICIPANT PHYSICIANS / SPECIALISTS' INFORMATION

Physician or specialist #1

Type of participation

◯ Co-treating ◯ Surgeon ◯ Anesthesiologist ◯ Physician assistant ◯ Other. Specify:

Last Name	Middle Name	First Name	Medical specialty

Board member ID	Specialty License Number	Estimated Medical fees

Physician or specialist #2

Type of participation

◯ Co-treating ◯ Surgeon ◯ Anesthesiologist ◯ Physician assistant ◯ Other. Specify:

Last Name	Middle Name	First Name	Medical specialty

Board member ID	Specialty License Number	Estimated Medical fees

I declare under penalty of perjury that the information contained in this document is true since it is provided in accordance with the medical evaluation that I have provided to the patient and in accordance with the knowledge and medical studies that I have performed or requested under my responsibility, also by the references of the patient himself or his relatives.

Place and date

Name and signature of the Treating Physician