GNP
Grupo Nacional Provincial

Av. Cerro de las Torres 395, Col. Campestre Churubusco
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Línea Azul®

MEDICAL REPORT, SURGERY PROGRAM AND/OR MEDICAL TREATMENT AND REIMBURSEMENT.

The physician is hereby notified that any false or misleading statement in this questionnaire will release the Company from all liability. This document will not be accepted with erasures or changes, nor will subsequent modifications will be accepted. (This questionnaire must be filled out and signed by the Attending Physician in legible handwriting.) We request that you not leave any questions blank or unanswered.

Please read and mark the parenthesis with an "x" if the answer is affirmative

Medical Report

Name of the patient

Date: day / month / year

Sex (M) (F) **Age** **Questioning** Direct ◯ Indirect ◯

Personal Record - not Pathological

	Smoking ( )	Alcoholism ( )	Drug Addiction ( )
Frequency			
Quantity			

Personal Pathology History (Even if unrelated to the current ailment)

Endocrine	( )	Oncological	( )	Psychiatric	( )	Urological	( )
Rheumatic	( )	Gastric	( )	Hematological	( )	Anesthesic	( )
Neurological	( )	Heart disorders	( )	Orthopedic	( )	Hospitalization for:	
Respiratory	( )	Trauma	( )	Othorhinological	( )	a) Surgery	( )
Immunological	( )	Others	( )	Gynecological	( )	b) Medical Treatment	( )

Please specify diagnosis, treatment and dates.

Gynecological History (Applicable only when the current ailment is Gynecological or Obstetric in nature)

Menarche _____ Last Period _____ Rhythm: Regular ( ) Irregular ( )

Pregnancy _____ Abort _____ Delivery _____ Cesarean _____ Section _____

Dismenorrhea ( ) Leukorrhea ( )

Date of the last Papanicolaou _____ Result _____

Have you ever undergone treatment to improve fertility? Yes_____ No_____ Which one _____

Since when _____ What were the results _____

Alterations in the mammary glands: Yes _____ No _____ Which one _____

Contraceptives Yes _____ No _____ Type _____ When did you begin to use them? _____

Pediatric History (Applicable to children under 16 years of age)

Pregnancy No. _____ Weight on date of birth _____ Delivery ( ) Cesarean ( ) Complications _____

Immunizations Scheme Complete ( ) Incomplete ( ) Remarks and Comments _____

Current Ailment (If due to an accident, please indicate how the injury ocurred)

1.- When did you attend this patient for the first time due to this ailment? _____

2.- When did the signs and symptoms start? _____

General description of the clinical symptoms. _____

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The actual ailment is:

Congenital Yes ____ No ____ Acquired ____ Yes ____ No ____ ¿How was it acquired? ____

Genetic Yes ____ No ____ Acquired ____ Yes ____ No ____

Physical Examination

Describe the positive data in connection with the actual ailment

Diagnosis

1.- Indicate the presumed diagnosis

2.- Indicate definitive Diagnosis: Mention them in order of appearance

3.- Which studies were performed to confirm the diagnosis (attach studies and results).

Treatment

1.- Does or did the patient take any medication? Yes ____ No ____ Name of medication ____

2.- Is he/she at present under any treatment? Mention medication and/or treatment carried out:

3.- Please list number of sessions ____ Doses ____ Remarks

4.- Treatment Plan ____

5.- Please indicate any surgery that has been carried out ____

6.- Please indicate any findings made during surgery. ____

7.- Rehabilitation Yes ( ) No ( )

Name and relationship of the person who provided this information: ____

NOTE: Please attach the results and the interpretation of the studies performed and a copy of the clinical history prepared for the affected individual.

Physician's Data

Name of the Surgeon or Treating Physician	Specialty	Address

Office Telephone No.	Telephone and Code No.	Cell Telephone No.	Registration No. Authorized by the Board

E-mail	Place	Date			
		Day	Month	Year	
					Signature of the Treating Physician

In the event of a surgery, in order to present the claim it is essential to fill completely out the following information:

Surgeon	Tax Payer Registration Number	Budget	
1st Assistant - Name	Tax Payer Registration Number	Budget	
2nd. Assistant - Name	Tax Payer Registration Number	Budget	
Name of the Anesthesiologist	Tax Payer Registration Number	Budget	
Treating Physician (in the event of treatment and/or rehabilitation)	Tax Payer Registration Number	Budget	No.of Sessions

By this document, I authorize any hospital, physician or other person who has medically examined me, to furnish Grupo Nacional Provincial, S.A. any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment that were rendered to me. A photostat/faxed copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization will allow Grupo Nacional Provincial, S.A. to use the information obtained to investigate and adjudicate my claims.

Scheduled Surgery and/or Medical Treatment (Accident or Illness Report)

IN ORDER TO PREVENT DELAYS, IT IS NECESSARY TO FILL OUT THIS FORM COMPLETELY, providing complete and detailed information. The fact that this form is presented does not mean that the Company is under the obligation to admit the validity of a claim, nor does the Company waive any of the rights to which it is entitled under the terms of the policy.
This questionnaire must be legibly filled out and signed by the policyholder.

STATEMENT BY THE CLAIMANT

This form will not be valid if it contains erasures or changes, nor will subsequent modifications be accepted after it has been delivered.
For further information, please see the instruction pamphlet attached to your policy.

Policyholder (Name or Employer)	Policy No.
Main Insured	**Certificate No.**

Information with respect to the Insured

Name of the Affected Insured	Relationship	Birthday		
		Day	Month	Year

Address	Telephone No.	Civil Status	Occupation	Age	Sex

Have you previously presented a claim for expenses for this ailment to this or any other company? Yes ◯ No ◯

Type of Claim: Initial ◯ Supplementary ◯ MME Claim No.:

Dealing with: Accident ◯ Illness ◯ Pregnancy ◯ Indicate diagnosis, reason for the claim: _____

If an accident, detail how and when it occurred	Date when the accident occurred or the first symptoms appeared	Day	Month	Year

In the event of an automobile accident, is there any automobile(s) insurance: Yes ◯ No ◯

Name of the Company	Coverage	Sum Insured (ME)	Policy No.

Please attach a copy of the report issued by the authorities or the hanling of the claim by the insurance company, as well as X-rays and the corresponding interpretation in the case of accidents involving the nose, mammary glands, fractures, etc.

Hospital to be admitted	Scheduled Date and Hour to be admitted	Hour	Day	Month	Year

Name of the Physician	Specialty	Does the physician form part of this company's medical care network?
		Yes ◯ No ◯

How was the Physician recommended? GNP Insurance ◯ Hospital ◯ Other ◯

I hereby authorize the hospital and the attending physician(s) to provide **Grupo Nacional Provincial, S.A.** or their representative with all the information relating to the illness or injury forming the subject matter of this claim, including the clinical files prepared by the hospital and physician, treatments and x-rays, all of which can be included as part of the evidence in connection with this claim. A photocopy of this authorization will be deemed to have the same effect and validity as the original.

Place and Date

Signature of the Insured

Name of the Agent	Code No.	Telephone No.	State

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Linea Azul Assistance

We are pleased to offer you our services 365 days a year, 24 hours a day, providing you with the following benefits:

1.- Information with respect to the coverage granted under your policy.

2.- Information with respect to procedures

3.- Preferential doctors' fees with specialists forming part of the Linea Azul Medical Network

4.- Discounts offered by medical suppliers.

5.- Telephone Medical Advice (free of charge).

5227 - 3333
México City

01 800 001 9200
(Lada sin costo)
Within Mexico

01 800 807 5697
(Toll free)
World Wide

Medical attention required outside of Mexico will be coordinated by Olympus Managed Health Care, Inc.

Toll Free USA
1 800 448 9698

MultiPlan

World Wide Coverage
(305) 530 9283

100 años
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