Prevem seguros

Medical Report

Instructions: This form must be completed in block letters and signed by each attending physician, except the Anesthesiologist and Assistant. It will not be valid if it contains erasures or alterations. It must be completed in its entirety. No changes to the information declared will be accepted thereafter.

Reason for visit:	☐	Direct payment	☐	Surgery-Treatment Scheduling			☐	Reimbursement		
Event type:	☐	Illness	☐	Accident	☐	In-network physician	☐	SI	☐	NO
	☐	Pregnancy	☐	Emergency	☐	Staff physician	☐	SI	☐	NO

A. Patient Identification Information.

Patient Name (Last Name, Maternal Last Name, First Name):

_____

Age: _____ Sex: ☐ F ☐ M

B. Medical History (specify duration, including dates of conditions and surgeries).

Past Medical History

☐ Cancer ☐ Cardiac ☐ Seizures ☐ Diabetes Mellitus

☐ Liver disease ☐ HIV / AIDS ☐ Other: _____

☐ Surgeries: _____

Past Non-Pathological History

☐ Smoker (specify amount): _____ ☐ Consumes alcoholic beverages (type and amount): _____

☐ Currently or previously used any type of drugs: _____

☐ Unintentional weight loss (describe): _____

☐ Other: _____

_____

_____

_____

Gynecological-Obstetric History

Pregnancies: _____ Deliveries: _____ C-sections: _____

Abortions: _____ LMP: _____ Gestational age: _____

Antecedentes Perinatales (si es necesario)

APGAR: _____ Silverman: _____

Current Condition (main signs and symptoms)

Date First Symptoms Began: _____ dd/mm/yyyy

Date of First Consultation: _____ dd/mm/yyyy

Date of Diagnosis: _____ dd/mm/yyyy

Please specify the evolution and current status of the condition:

Condition type: ☐ Congenital ☐ Acquired ☐ Acute ☐ Chronic ☐ Idiopathic

Has it been associated with any other condition, illness, or accident? ☐ Yes ☐ No

Which one?

Did the condition cause disability? ☐ Yes ☐ No ☐ Partial ☐ Total

RESULTS OF PHYSICAL EXAMINATION AND TESTS PERFORMED
(Attach interpretation confirming the diagnosis)

☐ Electrocardiogram ☐ Electroencephalogram ☐ CT Scan ☐ X-Ray
☐ Magnetic Resonance Imaging ☐ Blood ☐ Urine ☐ Histopathology
☐ Stool ☐ Other (specify):

Results:

Height _____ cms Weight _____ kg BP _____ mm/hg
HR _____ x1 RR _____ x1 Temp. _____ °C

Treatment Description:

Please indicate: ☐ Treatment Scheduling ☐ Description of Treatment Already Performed
☐ Surgical Treatmen (please specify procedure performed, surgical time, and date performed)
Date: dd/mm/yyyy

Description:

☐ Medical Treatment (please describe start date, treatment, and dosage)
Date: dd/mm/yyyy

Description:

Was there a complication? ☐ Yes ☐ No

Please describe complications:

Did the patient require hospitalization? ☐ Yes ☐ No

Hospital Name:

City:

Type of stay: ☐ Emergency ☐ Hospital ☐ Short Stay / Outpatient

Admission date: dd/mm/yyyy

Discharge date: dd/mm/yyyy

C. Attending Physician Information.

Name (Last Name, Maternal Last Name, First Name)

Provider No. (Only if the attending physician is in-network with Prevem Seguros, S.A. de C.V.):

Specialty: Professional License No.:

Specialty License or Certification: RFC:

Telephone: Mail:

Mobile:

Accepts payment from Prevem Seguros: ☐ Yes ☐ No Provider No.:

List the name and specialty of those participating in the procedure or as consultants:

Anesthesiologist:

Accepts payment from Prevem Seguros: ☐ Yes ☐ No

Assistant 1:

Accepts payment from Prevem Seguros: ☐ Yes ☐ No

Assistant 2:

Accepts payment from Prevem Seguros: ☐ Yes ☐ No

Other(s) Medic(s):

Accepts payment from Prevem Seguros: ☐ Yes ☐ No

The physician agrees to comply with the payment authorized by Prevem Seguros, without charging the insured any additional fees.

D. Signatures.

Note: As the attending physician, I authorize the hospitals where the patient was admitted to provide Prevem Seguros, S.A. de C.V. with all information concerning the patient's health, including all information regarding previous conditions. For this purpose, I waive professional confidentiality and authorize the use and processing of the information exclusively for the insurer's purposes. Under penalty of perjury, I state that the information provided in this form was obtained directly from the insured patient or responsible family members, in the case of minors or persons with disabilities, as well as from the medical record in my possession.

_____

Firma del Médico Tratante

Fecha: _____ dd/mm/yyyy _____

Lugar: _____