INBURSA Seguros

Doctor's Report
Major Medical Expenses

Note: Please Type In

Very Important: *Because of the fact that Seguros Inbursa, S.A Grupo Financiero Inbursa provides this form on researches a claim, it will not be obligate. To admit of any claim on of motiv being claimed, non is obligated to renounce to rights pertaining to it according to the law and to the clauses in this policy.*

Name of patient:

Date and place in which you flast helped the above mentioned person because of the injury or illnes.

Day Month Year

In: _____

_____

Date in which patient was injured or illnes began: *Day Month Year*

Illnes

Injuries you found: _____

_____

_____

Did the illnes or injury determine the disability of the patient for purposes of the performance of his/her usual occupations?

No ☐ *Yes* ☐ *Period of disability* *Day Month Year* *to* *Day Month Year*

Did you prescribe the patient's hospitalization? *No* ☐ *Yes* ☐ *At Patient's Home* ☐ *At Hospital or Clinic* ☐

Name: _____

Adress: _____

_____

Please describe the treatment you employed:

F-1859

"Este documento y la nota técnica que lo fundamenta, estan registrados ante la Comision Nacional de Seguros y Fianzas, de conformidad con lo dispuesto en el articulo 36 de la Ley General de Instituciones y Sociedades Mutualistas de Seguros, por oficio No. 3299 de fecha 03/mayo/1968."

Was a surgical procedure carried out? *No* ☐ *Yes* ☐ *Date* *Day Month Year*

Date in which patient was released because of recovery: *Day Month Year*

Patient´s regular doctor involved in this case:

Name	*Adress*

Do you know if patient has had a disease or physical malformation that may have predisposed the injury or that is related to the illness?

No ☐ *Yes* ☐ *Which?* _____

Do you know if the patient has illness or injury insurance policies with ot her companies?

No ☐ *Yes* ☐ *Which?* _____

_____

Any other comments?

Name of Doctor: _____

Speciality: _____

Address: _____

Telephone: _____ *Cell. phone:* _____ *Radio Telephone:* _____ *Key:* _____

Pofessional register number: _____ *Board certification number:* _____

As patient's practicing doctor, I do agree to allow hospitals, sanatoriums, clinics, doctor's offices, and laboratories which the insuree has contacted for the diagnosis or treatment of any illness or injury, to provide to Seguros Inbursa, S.A. Grupo Financiero Inbursa all information related to this case.

Date *Day Month year*

Insurance identification:

_____ _____

Doctor's Signature