Ficohsa

MEDICAL OPINION | CLAIM FORM
Seguros

For 24/7 service please dial * +504-2276-3960 (Service provided in Spanish)

Código: SPN-F.GSP-09

Policy No. _____ Certificate No. _____

Amount: _____ BPM: _____

To be filled by insurance company

I. General Information

1) Policyholder ☐ Spouse ☐ Child of primary subscriber ☐

2) Full name _____ Female ☐ Male ☐

3) Phone number _____ Email _____

4) DOB _____ Employer _____ Id.# _____

5) Do you or your spouse have a secondary insurance? Yes ☐ No ☐ Name the insurance company _____

6) Since when have you been insured? _____

II. Medical history / Outpatient consultation (To be filled by treating physician only)

1) Since when have you been treating the patient? Month _____ Day _____ Year_____

2) Cause of Condition:

Workplace accident ☐ Other accidents ☐ Common Disease ☐ Pregnancy ☐

Car Accident ☐ Occupational Disease ☐ HIV ☐

Positive Test Result Date

Month _____ Day _____ Year _____

3) Describe full diagnosis, injuries found, medical complications and treatments received: (Use ICD-10 Codes)

_____

_____

4) Initial diagnosis date or date accident occurred? Month _____ Day _____ Year_____

5) Has the patient previously been treated for the same or a diferent condition? Yes ☐ No ☐

If Yes, date of treatment _____ Treating physician _____

6) Tests, Procedure, Treatment or/and Surgery needed _____

Scheduled to happen on: Month _____ Day _____ Year_____

7) Medical Institution where medical treatment will be provided _____

Length of hospital stay required (do not use numbers) _____ Days

8) Total Procedure Fee (Please include all pre and post operatory related fees) $ _____

9) CPT Code Percentage _____ Percentage _____ Amount $ _____

CPT Code Percentage _____ Percentage _____ Amount $ _____

CPT Code Percentage _____ Percentage _____ Amount $ _____

CPT Code Percentage _____ Percentage _____ Amount $ _____

Can the treatment be done outpatient? Yes ☐ No ☐

Do you require assistance? Yes ☐ No ☐

Do you require an anesthesiologist? Yes ☐ No ☐

Do you require another physician's assistance? Yes ☐ No ☐

If yes, briefly describe additional physician's involvement _____

Is there a second medical opinion? Yes ☐ No ☐ If yes, provide date: Month _____ Day _____ Year_____

Name and address of physician who provided second opinion _____

Notes:

_____

_____

Physicians Name _____ Specialty _____ Signature and Stamp _____ Phone _____

Date and Place Signed _____

Hereby i certify the information and fees given. I authorize the physicians, hospital, or other medical entity and related individuals that provided any medical assistance to me or those related to me; to provide Ficohsa Insurance Company with all the medical records and billing documents.

Patient's signature _____

Company Name _____ Company HR Rep Name _____

Rep. Signature and Stamp _____