

MEDICAL REPORT FORM

To:
Phone:
Fax:

Patient:
Date of service:
Claim/File #:

In order to have the claims processed we need to receive this form properly filled.

Treating physician : _____

Diagnosis: _____

Is this a pre-existing condition? YES _____ NO _____

Onset date: / /

Prescribed treatment, including medications: _____

Is a follow-up visit required? YES _____ NO _____ If so, when? Date: / /

Is the patient clear to fly home? YES _____ NO _____

If not, please specify in detail the reason: _____

When is the patient expected to be clear to fly? Date: / /

Are there any special recommendations for the patient's flight back home? _____

Estimated Medical Expenses: USD \$ _____

This message is intended only for the use of the individual or company to which it is addressed and may contain information that is privileged and confidential. If you received this communication in error, please notify us immediately by telephone or fax. Thank you