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 $ _____