User report

USERS OF THIS DOCUMENT MUST ENSURE THAT THEY ARE USING THE MOST CURRENT REVISION OF THIS CONTROLLED DOCUMENT

Instructions:

1. User must complete the full form.
2. It will not be valid if it contains scratches or corrections.
3. Completing this form does not guarantee payment of the Assistance in Cash.

Date: _____

Place:

Holder's data

Company: _____

Holder's name: _____

Certificate number:

User data

User name: _____ Date of birth: _____

Kinship with holder: _____

email: _____

Telephone: Gender:

Claim details

Assistance for: Illness: ☐ Accident: ☐ Pregnancy: ☐

Name of Care Provider: _____

Date of first care provided: _____

Symptoms presented when seeking care: _____

Date when the first symptoms appeared:

Invoice list

Invoice #	Issuer	Concept	Amount
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		Total amount to be claimed:	$

Breakdown: if submitting a single invoice for multiple services, list each service by date.

Electronic Transfer Data

Account holder (MMS holder): _____

Bank:

Interbank Code (CLABE) (Enter one number per box, 18 digits)

_____

User name and signature

You must attach hereto the documentation required for Assistance in Cash.

Once patient signs this user report form, he/she authorizes both authorities, the administrator or the company depending therefrom, to have knowledge or information related to the medical care he/she requests, without reserving any action or right for events derived from this clause, as well as subsequent services with the same diagnosis.
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