

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

This form must be completed by the service provider, in print or digitally.

User Data

User name: _____
Age: _____ Gender: _____

Reason for Claim

Type of condition: _____ Illness: Pregnancy: Accident:

General Physical Data

Final diagnosis: _____
Date when the first symptoms began: _____ DD/MMM/YY
Initial date of patient care regarding this condition: _____ DD/MMM/YY
Subsequent: _____

Description of Care

Symptoms reported by user	Treatment to be followed by user
Diseases, pathological conditions, or history that gave rise to the basic or main disease	Significant conditions you have, even if they are unrelated to the diagnosis

Medical Referral

Were you recommended by another specialist: Yes No
Specialty: _____ Name: _____
Telephone: _____

Healthcare Provider Information

Name: _____ Specialty: _____
Licence Num.: _____ SSA REG.: _____
RFC (Tax ID): _____ Telephone: _____
Address: _____ State / City: _____

Place and Date

Signature

User's signature

USER authorizes Multiservicios Médicos Santander, S.A. de C.V., as well as third parties related to the provision of Medical Assistance, to access, know, transfer, and store the required information. In the case of a minor, it is understood that this form is filled out by the parent or guardian.

You can consult the comprehensive privacy notice at www.mmsantander.com.mx

Note: The information contained in this document is confidential and property of MMS. It is intended solely for the recipient(s) named herein. This document must NOT be disclosed without the authorization of MMS.

04-jul-24

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EFFECTIVE DATE