MAIN OFFICE
Av. 28 de Julio 873 Miraflores **Lima**, Perú, **T** (511) 213 3333 **P** 0801 1 1133 www.mapfre.com.pe

MAPFRE | PERÚ

MEDICAL INSURANCE

Request for Reimbursement, Outpatient and Inpatient Credit

CLIENT INFORMATION (must be completed by the policyholder for the Contracting Company)

CONTRACTING COMPANY	**POLICE NR.**
POLICYHOLDER	
ADDRESS	TELEPHONE NUMBER
EMAIL ADDRESS	MOBIEL TELEPHONE NUMBER
PATIENT	AGE
CLIENT'S OCCUPATION OR ACTIVITY	CITIZENSHIP

BANK ACCOUNT INFORMATION: BANK | **TYPE OF CURRENCY**

CONTINENTAL ☐ CREDITO ☐ INTERBANK ☐ SCOTIABANK ☐ | SOLES ☐ DOLLARS ☐

TYPE OF ACCOUNT | **NUMBER OF ACCOUNT**

SAVINGS ACCOUNT ☐ CURRENT ACCOUNT ☐ MASTER ACCOUNT ☐

KINSHIP

POLICYHOLDER ____
SPOUSE ____
CHILD ____
PARENT ____
OTHER ____

POINT OF CARE

NAME ____________
PRIVATE PRACTICE ____
CLINIC ____
MEDICAL CENTER ____

TYPE OF ACCIDENT

HOSPITALIZATION
OUTPATIENT
EMERGENCY ____

TYPE OF SERVICE

REMBURSEMENT ____
CREDIT ____

CONSENT CLAUSE FOR PERSONAL DATA TREATMENT IN BENEFIT REQUESTS

I hereby give my free, prior, express and unequivocal informed consent for MAPFRE to include my personal data, whether sensitive or not, included in this document, in its sities and databases, and to treat my information in the execution of the contract, i also expressly consent to the communication of my personal data to the entites and / or persons to whom MAPFRE will entrust the fulfillment of certain activities for the development of the service contracted and exclusively for that purpose, knowing that MAPFRE ensures the confidentiality of my data and guarantees it will not share them with outsiders, except as indicated in this document.

DATE | FIRM AND STAMP OF CONTRACTING COMPANY | POLICYHOLDER'S SIGNATURE

(RESERVED FOR COMPANY)

CODES	CONTINUITY

MEDICAL AUDIT

CODE OR REQUIREMENT	CODE OR REQUIREMENT	CODE OR REQUIREMENT

DATE | SIGNATURE AND APPROV | **DATE** | SIGNATURE AND APPROV | **DATE** | SIGNATURE AND APPROV

COMMENT: IN CASE OF REIMBURSEMENT THE EXPENSES MUST BE PRESENTED WITHIN 30 DAYS AFTER INVOICING AND IN THE FOLLOWING MANNER: ALL PROOF OF PAYMENT (RECEIPT FOR FESS, INVOICES, BILLS) MUST BE ISSUED WITH THE POLICYHOLDER'S NAME (PATIENT)

(TO BE FILLED IN BY TREATING PHYSICIAN

Clearly indicate date of diagnosis or beginning of symptons, point of treatment and name of treating physician

PATHOLOGICAL ANTECEDENTS

CURRENT ILLNESS (If accident, state date and circumstance)

AUXILIARY EXAMS

DIAGNOSES

MEDICAL OR SURGICAL TREATMENT

PROGNOSIS

ABOUT HOSPITALIZATION

CLINIC	ROOM	MEDICAL RECORD

ENTRY DATE	EXIT DATET

TREATING PHYSICIAN'S INFORMATION

NAME	SPECIALITY	TELEPHONE NUMBER

C.M.P	R.E	R.U.C	R.P.I

DATE

SIGNATURE AND STAMP

DESCRIPTION OF THE PRESENTED EXPENSE:

DESCRIPTION OF THE TREATMENT AND/OR CARE	DIAGNOSIS / PATHOLOGY TREATED	SPECIALTY	NAME OF MEDICAL PROVIDER	AMOUNT INVOICED AND CURRENCY OF THE RECEIPT