BlueCross BlueShield Panama

REQUEST FOR FOREIGN ATTENTION

THIS FORM MUST BE SENT TO OUR FAX 011-507-210-1077 - INTERNATIONAL DEPARTMENT -Phone number: 011-507-206-4257 - e-mail: dmoreno@iseguros.com

Name of the Patient: _____ Sex: M ☐ ☐ F

Date of Birthdate: _____ Policy No. _____

Number of Personal ID: _____ Certificate: _____

CLINICAL HISTORY OF THE PATIENT (DIAGNOSTICS, NAME OF DOCTORS THAT HAS EVALUATED THE PATIENT IN PANAMA)
AND THE REASONS THE INSURED WAS REFERRED TO YOUR MEDICAL SERVICES.

DESCRIBE THE REASONS FOR THE MEDICAL ATTENTION OUTSIDE OF PANAMA AND THE PROCEDURES RECCOMMENDED
THAT ARE NOT SUPPLIED BY MEDICAL CENTERS OR PHYSICIANS IN PANAMA.

DESCRIBE ANY FUTURE PROCEDURES THAT THE INSURED WOULD REQUIRED AND NEXT SCHEDULED PROGRAM FOR THE PATIENT.

WRITE DOWN THE NAME AND THE ADDRESS OF THE HOSPITAL, PHYSICIAN, PHONE NUMBERS OR E-MAIL IN ORDER TO COORDINATE
THE BENEFITS WITH OUR PROVIDERS.

Signature of Physician: _____ Date: _____