medusa group

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MEDICAL REPORT & ASSESSMENT

Insurance Ref. / Case No: Reference number medex:

Family Name:	Travel Agency: .....
First Name:	Hotel and Room No: .....
Date of Birth:	Insurance Comp: .....
Nationality:	Insurance No: .....
Home Tel. No:	Arrival Date: .....
Full Home Address:	Return Date: .....
.....	e - mail address: .....
Postal code : .....City:	.....

Patient's Complaints: .....
.....

T:..... ℃ P: ..... beat/min BP:...../..... mmHg SpO2::.....%

Visit Date	Place of treatment	Time	Patients's Signature (each visit)	Doctor

Laboratory:

Radiology:

Diagnosis:

Doctor's comments

Medications :

Observation:

Yes ☐ If yes: from.....to..... No ☐

Medcar transportation / ambulance :

I comfirm that the above information is correct

Doctor's signature: Patient's signature:

Total costs:	
Excess:	
Final total costs:	

I ....., fully understand, irrespective of the status/validation of my insurance for travel, health, accident or injury, agree to assume full liability and responsibility for payment of any and all costs of medical treatment provided to me, including but not limited to, the cost of emergency personnel, ambulance transfer (ground, sea, air), emergency room services, medical clinic costs, radiology, lab tests, daily room charges/ observation, medicine fee, independent physicians, specialist and transportation charges that my insurance company may decline to pay on my behalf.

MEDUSA medical company ltd. reserves the right to bill the patient when the insurance company does not provide medical coverage for the medical treatment/ services received before the departure date.

In the event that I am billed directly from **MEDUSA** medical company ltd. or a debt collection/ legal agency, I am aware that the bill must be paid within 10 days upon receiving the invoice or notification, any delayed payments will have a surcharge of 5% of the grand total and any fees incurred by **MEDUSA** to recover the funds I.E Debt. collection and Legal fees will be added onto the debt.

I also agree and give full consent to **MEDUSA** medical company ltd. to forward all my details and all medical records to any third parties involved.

Full name of patient:.....Name of next of kin:.....

Patient or Next of kin. signature:..... Date:.....

By signing the above I am fully responsible for the invoice or remaining balance of what my insurance company may not pay on my behalf.

ACCIDENT/ INJURY DETAILS

Location of Accident/injury:.....

Time of Accident/injury:.....

How did the Accident/injury occur?:.....

.....

.....

GP DETAILS

Name of GP:.....

GP address:.....

GP telephone:.....

FIT TO FLY

Oxygen: yes - no ..... Stretcher: yes - no ..... Is the patient able to walk to the aircraft seat: yes - no
Be able to climb the aircraft stairs: yes - no
I certify that the patient..... .....is fit to fly within 24 hrs of the consultation and signing of this document.
Patient is suffering from:.....
In my opinion is medically fit to travel by air and is not infectious.

Dr. Comments:.....
.....
.....

Doctors Stamp & Signature **Date:…./…./…….**