

## **OUT OF COUNTRY MEDICAL REQUEST FORM**

To be completed for referrals/ pre-certification for out of country treatment
(To be completed by the Referring Physician)

Na	ame of Patient:				
Address:		Tel:	(H)	(W)	
1.	Brief Medical History:				
2.	. Describe previous care/surgery (Include names of physicians):				
3.	3. Type of service requested out of country (state country to which patient is being referred):				
4.	To the best of your knowledge can this treatment be rendered locally/regionally?				
5.	5. Expected date of travel:				
6.	Previous records in possession of Patient or Physician?				
7.	Name of Physician/Provider and address to whom patient is referred:				
 To	Referring Physician's Signature be completed by the Employer:	Pl	ease print name and	indicate specialty	
Na Pa Da	roup Number:  tient Name:  tte of Birth (Patient):  fective date of Coverage (Patient):	Effective date Relationship to	of coverage: Employee:		
Si	gnature of Employer	Date		20	