UNDP MIP – PRIOR AGREEMENT FORM

Please return to: GMC's Medical Advisory Board – 10, rue Henner – 75459 Paris Cedex 09 – FRANCE
Fax: +33 1 40 82 43 85 – E–mail: gmc.medical@henner.com

Suscriber			
Last name *:			
First name *:			
GMC ID No. *:		Sex *:	

If the Patient is not the Suscriber			
Last name:			
First name:			
Date of birth (MM/DD/YY):	/ /	Sex:	

Is the claim covered by another insurance? If yes, please provide details below.	Yes		No	
Is the present illness or injury a result of an accident? If yes, please provide details below.	Yes		No	
Is the present illness or injury considered to be sevice occured? If yes, please provide details below.	Yes		No	

Hospital:

Name of facility *:
Address *:
Tel *:
Fax:
E–mail:

Attending Physician:

Name *:
Address *:
Tel *:
Fax:
E–mail:

State medical diagnosis/Reason for the hospitalization/Clinical symptoms *:

Proposed procedure/Treatment programme *:

Nature of any additional examination to be carried out:

Date of admission (MM/DD/YY) *:	/ /		Length of stay *:		
Date of discharge (MM/DD/YY):	/ /		Is it an extension of stay? *	Yes	No
Indicate type of room chosen by the patient (*please tick the relevant box*) *:	– Private room:				
	– Semi–private room:				
	– Ward:				

Expected cost of the hospitalization *:

Country *:			
Hospital expenses (*please specify*) *:		Price of room (*per day, incl. currency*) *:	
		Physician's fees (*incl. currency*) *:	

Physician's seal and signature *:
Date (MM/DD/YY) *: / /
GMC's Medical Advisory Board: + 33 1 40 82 43 02

Patient's signature *:
(If the patient is a minor: a parent or a guardian. If the patient is unable to complete/sign: a) his/her spouse or an adult family member; or b) a UNDP officer but only if there is no spouse or adult family member present to complete/sign). I hereby authorize my Physician to send to GMC's Medical Advisors all the medical information required for making a decision on my file.

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Attention!

Detailed information on all types of rooms is mandatory to process the Prior Agreement Form.
If no semi−private rooms exist in the Hospital, please fill out the declaration below.

Declaration

I hereby certify that no semi−private rooms exist in our Hospital.

Representative's name:

Signature and seal:

* All information requested is mandatory