sencard

PRIVATE HEALTH INSURANCE PATIENT INQUİRY FORM

This form should be filled with complete and accurate information received according to the information gained from the patient, diagnosis of physicial examinations, test results and policlinic records. For non-emergency treatments and surgeries, provisions should be provided 24 hours prior to the treatment/surgery.

Provision/Contact Information	Phone: (216)- 571 5656 Fax: (216)- 571 5657-58-59	Provision Nr :

This section will be filled out by the Health Institution

Instution Name	Instution Code	Phone Nr	Fax Nr
Insured's Name - Surname			
Date Of Birth	...../...../.....	Gender	☐ Male ☐ Female
Policy Nr		Card Nr	
Identification Nr.		Contact Phone (Home)	
Identification Card Nr.		Contact Phone (GSM)	
Application Date	...../...../.....		
Address			
Admission / Expiry Date	...../...../.....	...../...../.....	

This section will be filled out by the physician who completed the examination

Complaints of the Patient/Story			
Initial Date of the Complaint	...../...../..... (Last Period Date if Pregnant) ...../...../.....		
Was there a prior sittuation caused a physician consult, examination and have you been treated by the same complaint/condition? (Consulted health institution/ name of the physician)			
Patient History / Drugs used			
Diagnosis of Physical Examination			
Examinations / Results		ICD 10	
Pre Diagnosis / Diagnosis		☐ Out-Patient ☐ Surgicial ☐ Emergancy ☐ Forensic Case ☐ Observation ☐ Pregnancy	
Planned Treatment / Process			

Physician's Name/Surname	☐ Contracted ☐ Non-Contracted	Operator	
Specialty		Anesthesia	
Cpntact Phone		Asisstant	
Signature / Cachet			

Küçükbakkalköy Mah. Başar Sok. No:20 34750 Ataşehir - İstanbul Tel: +90 216 571 55 55 Faks: +90 216 571 55 56 MERSİS No: 0153003619800017
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www.sencard.com.tr

I nsured / Policy Holder / Decleration of the Legal Representative

I declare and accept that the information stated above are exactly correct and accurate, I give full responsibility to the insurance company to gain all information and documents about myself and my family regarding our mentioned/other conditions.

Insured / Policy Holder	:	
Name/Surname of the Legal Representative	:	
Signature	:	Date:
Date	:	

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