



OUT OF COUNTRY MEDICAL REQUEST FORM TO BE COMPLETED BY REFERRING PHYSICIAN

Name of Patient: _____

1. Brief Medical History:

2. Describe previous care/surgery (include name of Physicians):

3. Type of service requested in the U.S.A. / Other:

4. Expected Date of Travel: _____

5. To the best of your knowledge, can this treatment be rendered locally?

6. Previous records in possession of Patient/Physician:

7. Name Physician/Provider and address referred to:

Referring Physician's Signature

TO BE COMPLETED BY THE EMPLOYER

Group Number:		Group Name:	
Name of Employee:			
Patient Name:			Relationship:
Date of Birth:		Effective Date of Coverage:	

Signature of Employee

Signature of Employer

Date

**Please note that this form must be submitted to Sagicor Life Inc. a minimum of 10 days
prior to recommended treatment out of country.**