
GMC International Medical Board

Hospitalisations, most series of procedures as well as dental prosthetic treatments will be submitted to the prior agreement of the GMCI Medical Board. Of course, this is a constraint for you. But it is also a high-level «quality assurance» designed for your security.

Our highly qualified French-trained consulting practitioners, selected for their international experience, have a network of specialised consultants on whom they can call whenever they deem it necessary, and provide a number of guarantees for the families of GMCI Members:

- ***They ensure that proposed treatments involve no unnecessary, dangerous or inappropriate procedures.***
- ***They ensure the coherence of diagnoses and treatment plans.***
- ***They place great importance on continuity of the treatments given by supplementing medical care programmes, if required.***
- ***They propose, for the most serious cases, possibilities of hospitalisation in internationally recognised institutions, located in France.***
- ***They are at your disposal to advise you or to explain to you the reasons for a wholly or partly negative medical opinion.***
- ***Lastly, they verify that the rates quoted – even when high – are consistent with practices in the country where the medical care is provided.***

We often ask you for additional information in order to process your prior agreement applications. You now know why!

PRIOR AGREEMENT APPLICATION – HOSPITALIZATION

Hospitalization may be refunded by GMC International Administration only if they are the subject of a prior agreement of our Medical Board, on the basis of this document, which must be completed by the Physician and sent by post or fax to:

GMC International Medical Advisor - 10 Rue Henner 75459 PARIS Cedex 09

Fax: +33 1 40 82 43 85

This form must be sent no later than 15 days prior to the date of hospitalisation.

In the event of a medically justified emergency, this form must be sent within 3 days following admission.

The Medical Board's agreement to the hospitalization will authorise issuance of an undertaking to reimburse, which will be sent directly to the designated institution. The Medical Board will notify the patient in the event of a refusal.

Insured person's surname and first name:

GMC Id No.:

Patient's surname and first name:

Date of birth:

Sex:

Is the current prior agreement application in direct relation with an accident? Yes No

If yes, please attach to this document a detailed report describing the circumstances of the accident.

TO BE COMPLETED BY THE ATTENDING PRACTITIONER

Proposed place of hospitalization (name of institution, address, telephone, fax, e-mail):

Attending physician (name, address, telephone, fax):

Reason for the hospitalization / Clinical symptoms presented / Precise medical diagnosis:

Nature of the proposed intervention and treatment programme:

Nature of any additional examination to be carried out:

Length of stay:

Date of admission:

For a stay of:

Is it an extension of stay (y/n)?

Detailed estimated cost of the hospitalization:

Hospital charges:

Physicians' fees:

Other cost elements:

Physician's seal and signature:

Date:

For medical information: +33 1 40 82 42 49

Patient's signature:

I hereby authorise my Physician to send to GMC International medical advisor all the medical information required for making a decision on my file.

PRIOR AGREEMENT APPLICATION – DENTAL TREATMENTS

Major dental treatment will be reimbursed by GMC international Administration only when they are the subject of a prior agreement by our Medical Board, on the basis of this document, which must be completed by the Practitioner and sent by post to:

GMCI Medical Advisor - 10, rue Henner 75459 PARIS Cedex 09 - Fax : +33 1 40 82 43 85

This form must be sent no later than 15 days prior to the date on which treatment is scheduled to begin.

Insured person's surname and first name:

GMC Id No.:

Patient's surname and first name:

Date of birth:

Sex:

Is the current prior agreement application in direct relation with an accident? Yes No

If yes, please attach to this document a detailed report describing the circumstances of the accident.

Note!

The documents that must be submitted with this form are written in italics.

In all cases (orthodontics / dental prostheses / periodontics / implantology),

return this application and include a detailed cost estimate of the entire treatment

TO BE COMPLETED BY THE ATTENDING PRACTITIONER

ORTHODONTICS

If the application pertains to a mixed dentition intervention:

Does it concern a proscia rehabilitation (y/n)? _____

Does it concern an early an interceptive orthodontic apparatus (y/n)? _____

Anticipated duration of the mixed dentition treatment (months): _____

If the therapeutic plan involves final dentition, indicate all of the following values:

If the Ricketts analysis is used,

complete items R1-R2-R3-R4 + 5 to 11

R1. Facial angle in degrees: _____

R2. HFI in degrees: _____

R3. Convexity in millimetres: _____

R4. DDM in millimetres: _____

5. Molar dental class with gap measured in millimetres: _____

6. Supra-occlusion or infra-occlusion measured in millimetres: _____

7. Dental arch contraction or dental arch expansion in relation to the number of teeth concerned: _____

No anomaly: _____ Isolated anomaly of a tooth: _____ Multiple anomalies _____

8. Lower incisor angle / NaPog in degrees: _____

9. Angle 11/41 or 21/31 in degrees: _____

10. Free margin distance 11/41 or 21/31 in millimetres: _____

11. Anticipated duration of the final dentition treatment (in months): _____

If the Tweed analysis is used,

complete items T1-T2-T3-T4 + 5 to 11

T1. FMIA in degrees: _____

T2. IMPA in degrees: _____

T3. ANB in degrees: _____

T4. Total DDM: _____

Pathology of at least an entire area: _____

DENTAL PROSTHESES

Return this application and include the following documents and information:

Dental panoramic radiograph of more than 3 teeth and alveolar retrusion or RVG images after endodontic treatment or resumption of treatment

Devitalised tooth (teeth n°) _____

Vital tooth (teeth n°) _____

PERIODONTICS

Return this application and include the following documents and information:

Alveolar retrusion assessment (status) + Number of dental quadrants/area concerned + Diagnosis + Treatment plan

IMPLANTOLOGY

Return this application and include the following documents and information:

Dental panoramic radiograph + Implant area (number of teeth to be replaced by implants) +

Report including available bone height in implant area + Possible contraindications

Physician's seal and signature:

Date:

For medical information: +33 1 40 82 42 49

Patient's signature:

I hereby authorise my Physician to send to GMCI medical advisor all the medical information required for making a decision on my file.

PRIOR AGREEMENT APPLICATION – SERIES OF PROCEDURES AND PROSTHESES

Series of procedures may be refunded by GMC International Administration only if they are the subject of a prior agreement of our Medical Board, on the basis of this document, which must be completed by the Practitioner and sent by post or fax to:

GMC International Medical Advisor - 10 Rue Henner 75459 PARIS Cedex 09 - Fax: +33 1 40 82 43 85

This form must be sent no later than 15 days prior to the date scheduled for the beginning of the treatment.

Insured person's surname and first name:

GMC Id No.:

Patient's surname and first name:

Date of birth:

Sex:

Is the current prior agreement application in direct relation with an accident? Yes No

If yes, please attach to this document a detailed report describing the circumstances of the accident.

TO BE COMPLETED BY THE ATTENDING PRACTITIONER

The following procedures are subject to this prior agreement application:

Type 1 treatments: Acupuncture, chemotherapy, dialysis, electrotherapy, physiotherapy, radiotherapy, kinesitherapy, speech therapy, orthoptics, nursing care, medical prostheses (1).

Type 2 treatments: Psychiatric or psychotherapeutic treatments (may be refunded only if treatments given by a physician)

(1) Medical prostheses: enclose the prescription

TYPE 1 TREATMENTS

Pathology presented:

Nature of procedures:

Number of procedures:

Total cost:

TYPE 2 TREATMENTS

Description of the clinical symptoms:

Diagnosis:

Medical history:

Family history:

Patient's personality:

Type of therapy considered:

Behavioural contract:

Purpose of the therapy with expected results:

Total number of sessions:

Frequency of sessions:

Cost of each session:

Physician's seal and signature:

Date:

For medical information: +33 1 40 82 42 49

Patient's signature:

I hereby authorise my Physician to send to GMC International medical advisor all the medical information required for making a decision on my file.