



**DECLARATION/COMMITMENT OF PAYMENT** (in case of not accrediting the right to assistance)

DATA OF THE PATIENT			
Name and surname		NHC	
DNI/NIE/Passport		Date of birth	
Nationality		Telephone	
Type of financing			
Company			
Email			
Address			
Date and time of request or assistance			
DETAILS OF THE REPRESENTATIVE/TUTOR			
Name and surname			
DNI/NIE	Telf	Email	
Address			

DATA TO BE COMPLETED IN CASE OF A TRAFFIC ACCIDENT			
Accident date		Crash site	
The injured person is: <input type="checkbox"/> Driver <input type="checkbox"/> Occupant <input type="checkbox"/> Pedestrian <input type="checkbox"/> Cyclist <input type="checkbox"/> Others (check the appropriate)			
Name and surname of other injured:			
DETAILS OF THE VEHICLE WHERE YOU WERE TRAVELING OR THAT HIT YOU			
Car license plate		Brand	Model
Insurance company		Nº policy	
Driver		Telephone	
Address			
Insured		Telephone	
Address			
DATA OF THE OPPOSING VEHICLE:			
Car license plate		Brand	Model
Insurance company		Nº policy	
Driver		Telephone	
Address			
Insured		Telephone	
OBSERVATIONS:			



## Declares

- ❖ That, on the indicated date, he requests or has received health care at this Center.
- ❖ That if you have not proven your right to receive Health Care in the National Health System, you are informed that you must submit the relevant supporting documentation.
- ❖ In the event of requesting assistance as a private individual, you agree to assume the expenses generated by the assistance received.

According to art. 73 of Law 39/2015, of October 1, on the Common Administrative Procedure of Public Administrations, must send the documentation within 10 days, from the day following the notification, to the Servicio de Facturación a Terceros del Área de Salud II. If it is not received, the invoice may be issued to the patient or their representatives, and they must take charge of the expenses generated by the assistance.

And for the record and to have the appropriate effects, sign

Sign: \_\_\_\_\_

### TREATMENT OF PERSONAL DATA.

The person in charge of the treatment of the personal data indicated in this form is the Managing Director of the Murcian Health Service, with address C/ Central nº 7. Edificio Habitamia I. 30100-Espinardo (Murcia) and you can contact the Delegate of Data Protection in the email dpd-sms@carm.es.

The necessary treatments, covered by compliance with the regulations, are the communications, transfers of data necessary for the determination, processing, notification and collection of the acts of liquidation of public prices, by virtue of the provisions of article 83 of Law 14 /1986 General Health of April 25 and the Order of February 2, 2023 of the Ministry of Economy, Finance, European Funds and Digital Administration, by which the rates of applicable public fees and prices are published.

The recipients of assignments or transfers may be judicial bodies, other bodies of the Autonomous Community of the Region of Murcia, other bodies of the State Administration, mutual societies, assistance companies and insurance companies (if they belong to them). As the owner of your personal data, you can exercise before the person responsible for data processing the rights of access, rectification, deletion, opposition and limitation of treatment. These rights may be exercised through the model forms that are available at the User Service. Likewise, they can file a claim with the competent Data Protection Control Authority, especially when they have not obtained satisfaction in the exercise of their rights.

All this in application of current regulations: Regulation (EU) 2016/679 of the European Parliament and of the Council of April 27, 2016 regarding the protection of natural persons with regard to the processing of personal data and the free movement of these, and Organic Law 3/2018, of December 5, Protection of Personal Data and guarantee of digital rights.

<b>DOCUMENTATION TO PRESENT (depending on the case):</b>	
<input type="checkbox"/> <b>Work accident.</b> Copy of the sick leave or accident report issued by the Mutual Company. You must notify your company so that it can send said report (with or without sick leave) to the Accident Insurance Company. Company Name: _____ Mutual Company: _____ If there are witnesses: Name: _____ Telephone: _____	
<input type="checkbox"/> <b>Traffic accident.</b> Statement of liability in case of stolen/uninsured vehicle.	
<input type="checkbox"/> <b>School accident.</b> Copy of the accident report issued by the private/subsidised school Name of the Private/Concerted school: _____	
<input type="checkbox"/> <b>Sports accident.</b> Copy of the federated card and accident report issued by the club or sports mutual.	
<input type="checkbox"/> <b>Mutual members (ISFAS, MUFACE...), private companies and non-EU foreigners.</b> You must notify the health care within 24 hours to your company. You must provide a payment commitment issued by it within a period of 10 days.	
<input type="checkbox"/> <b>Foreign individuals from the Community or with an international agreement.</b> They will present a European Health Card, S1, S2 or an equivalent document that has not expired. If so, you must request and send us a Substitute Provisional Certificate.	
<input type="checkbox"/> <b>Aggressions</b> If you are going to file a complaint, fill in: Number of proceedings opened in court: Court No.: _____ Location: _____	
<input type="checkbox"/> <b>Mandatory insurance</b> If there is compulsory insurance, you must notify your company of assistance as soon as possible and request a commitment to pay, which you must send.	

According to art. 73 of Law 39/2015, of October 1, on the Common Administrative Procedure of Public Administrations, must send the documentation within 10 days, from the day following the notification, to the Servicio de Facturación a Terceros del Área de Salud II, through the email facturacion.area2.sms@carm.es or in person in block 3, 2nd floor, of the Hospital General Universitario Santa Lucía.