

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Yin Yin Aye
Card No : I040-029-117580473-01
Policy Holder : Yin Yin Aye

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Female

Date Of Birth : 01-Jun-1977

Patient's Tel No : 0555402967

Service Date :17-May-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Humaira

Network : Green

Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : co cough dry pain in throat body pain fever 3 days oe chest is congested no added sounds restlesss irritable

Vitals:Temp : 37.7 Bp :124 Pulse :85 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R50.9 - Fever, unspecified,R52 - Pain, Date of Onset :17/00/2024 unspecified,

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAZONE-TABUK IV-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION,85008, BLD COUNT SMEAR MCRSCP W/O MNL DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated :

Cost

Prescriptions: 0252-179601-1161 - (AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,

Estimated :

Cost

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

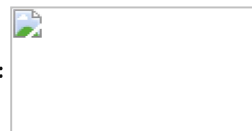
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient's signature{Parent : if minor}



17-
Date : May-
2024

Signature :

Date : 17-May-2024