Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Surendra Kumar Chaudhri**
Card No	**: I040-029-117537322-01**
Policy Holder	**: Surendra Kumar Chaudhri**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 18-Apr-1988**
Patient's Tel No	**: 0522963916**

Service Date **:18-May-2024** **Network** **:** Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

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 : **Duration** :

Vitals:

Clinical Findings:

Diagnosis: K61.39 - Other ischiorectal abscess,K60.0 - Acute anal fissure,D72.829 - Elevated white blood cell count, unspecified, **Date of Onset** :18/48/2024

Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: **Estimated Cost** :

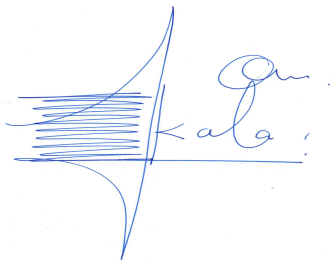
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : Enomen Goodluck

Stamp :

Signature :



Date : 18-May-2024

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.

Patient 's signature{Parent if minor} :

Date : 18-May-2024