Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Sachin Pandurang Vinherkar**	**Service Date**	:**22-May-2024**
Card No	: **I040-029-113718954-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **Sachin Pandurang Vinherkar**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **07-Jan-1984**		
Patient's Tel No	: **0503667303**		

Network : Green

Direct Access SP - YES

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

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Fever and cough since the past two days. Fever is worst in the evenings. Also has recurrent raised, hyperpigmented scaly rashes on the sole of the feet and palm of the hands. **Duration:**

Vitals: Temp : 36.5 Bp :132 Pulse :77 Resp :20

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J20.9 - Acute bronchitis, unspecified,L43.0 - Hypertrophic lichen planus,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :22/55/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 1516-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

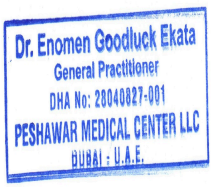
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Enomen Goodluck

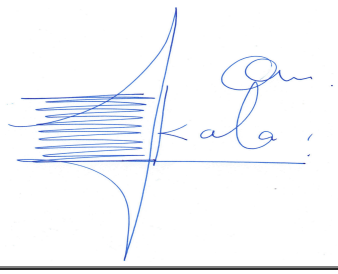
Stamp :



Patient 's signature{Parent if minor} :

Date : 22-May-2024

Signature :



Date : 22-May-2024