Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AGGREY ONYANGO**
Card No	**: I040-029-116125957-01**
Policy Holder	**: AGGREY ONYANGO**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Green Network**
Validity	**: 01-01-2024** To **31-12-2024**
Gender	**: Male**
Date Of Birth	**: 12-Nov-1983**
Patient's Tel No	**: 0543892858**

Service Date :**30-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 : Symptoms: Nasal congestion, cough Duration: 27/05/2024 (3days) History of **Duration:** presenting complaint: cough is dry and there is no fever, also has a bit of sorethroat. Also requesting for general medical examination and investigation for pre employment purposes. Family history: not relevant. Social history: does not smoke and does not take alcohol. Plan: Reveiw with investigation results.

Vitals: Temp : 36.5 Bp :140 Pulse :0 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,Z00.00 - Encntr for general adult medical exam w/o abnormal findings, **Date of Onset** :31/01/2024

Requested Investigations: 87177, ROUTINE EXAMINATION, STOOL,87045, CULTURE & SENSITIVITY MANUAL, STOOL,85025, COMPLETE BLOOD COUNT (CBC), BLOOD,87340, HEPATITIS B SURFACE ANTIGEN (HBSAG), SERUM,86703, HIV 1 & 2 ANTIBODIES (HIV 1 & 2 / P24 ANTIGEN), SERUM,10008, ECG,81001, ROUTINE EXAMINATION, URINE,86803, HEPATITIS C ANTIBODY (HCV), SERUM,9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT **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.

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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 31-May-2024

Signature : **Date** : 31-May-2024