

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MEVAN DILSHAN PEIRIS
BADDE LIYANAGE DON

Card No : I040-029-118251299-01

Policy Holder : MEVAN DILSHAN PEIRIS
BADDE LIYANAGE DON

Payer Name : UNION INSURANCE
COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 14-Jul-1995

Patient's Tel No : 0526048378

Service Date:03-Jun-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Enomen Goodluck

Co-Insurance :

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

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : PC: Left lumbar pain Duration/onset: 28/05/2024 (5days) HPC: pain waxes and wanes (colicky in nature) and has been recurrent. Began again today with much severity thus necessitating his presentation. There is no fever and he has no irritative symptoms. Past Medical History: Has no history of similar condition in the past, not hypertensive and not diabetic. Has no other chronic medical condition. Family history: not relevant Social history: smoke tobacco of 4 sticks per day, takes alcohol once weekly Review with investigation reports tomorrow.

Vitals:Temp : 37.2 Bp :137 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: N20.2 - Calculus of kidney with calculus of ureter,R52 - Pain, unspecified,N39.0 - Urinary tract infection, Date of site not specified, Onset :03/52/2024

Requested Investigations: 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Consultation GP

Estimated Cost :

Prescriptions: 0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

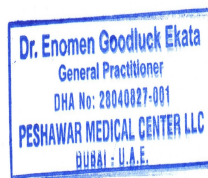
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

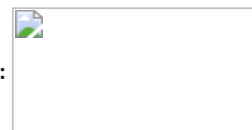
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



Date : Jun-2024

Signature :

Date : 03-Jun-2024