

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : BINDA DAHAL . THAPA
Card No : I040-029-120575235-01
Policy Holder : BINDA DAHAL . THAPA
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2024 To 01-01-2025
Gender : Female
Date Of Birth : 25-Sep-1997
Patient's Tel No : 0564692668

Service Date :11-Jun-2024
Health Provider :Irham Medical Center Arjan
Doctor's Name :Enomen Goodluck

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 : PC: Headache, fever, blocked nose, cough and pain in throat. Duration: 2days
(09/06/2024)

Vitals:Temp : 38.1 Bp :110 Pulse :67 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R53.1 - Weakness,R42 - Dizziness and giddiness,K29.00 - Acute gastritis without bleeding,R11.10 - Vomiting, unspecified, **Date of Onset** :11/03/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-242802-0781, PANTONIX 40MG I.V.,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated : Cost**

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0137-174201-1452 - (OMEPRazole : 20 MG) CAPSULES (HARD GELATIN),0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, **Estimated : Cost**

MEDICAL PRACTITIONER DECLARATION :

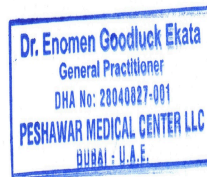
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

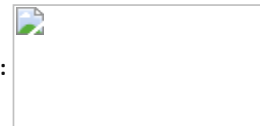
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



11-
Date : Jun-
2024

Signature :

Date : 11-Jun-2024