Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MD . ALOMGIR**
Card No	**: I040-029-120327297-01**
Policy Holder	**: MD . ALOMGIR**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 01-Jan-1999**
Patient's Tel No	**: 0543772098**

Service Date **:24-Jun-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 : PC: hypopigmented circular patches on the skin. Duration: 2months (13/04/2024). Given Itrazol and sulfure soap **Duration:**

Vitals: Temp : 36.4 Bp :124 Pulse :56 Resp :20

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified,L29.8 - Other pruritus, **Date of Onset** : 25/27/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 0137-268402-1451 - (ITRACONAZOLE : 100 MG) CAPSULES (HARD GELATIN),

MEDICAL PRACTITIONER DECLARATION :

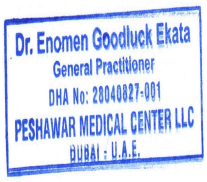
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

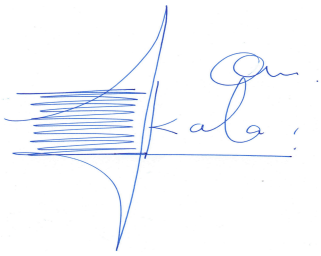
Stamp :



Patient 's signature{Parent if minor} :

Date : 25-Jun-2024

Signature :



Date : 25-Jun-2024