

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MANIKANDAN
Card No : I040-029-113722474-01
Policy Holder : MANIKANDAN
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2023 To 01-01-2024
Gender : Male
Date Of Birth : 05-Oct-1992
Patient's Tel No : 0528231211

Service Date : 28-Oct-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Sajid Sanaullah

Network : Green
Direct Access SP - YES

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 : High fever and body pain and severe sore throat since two days started on 26/10/2023

Vitals: Temp : 38 Bp :100 Pulse :88 Resp :24

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified, R05 - Cough, R07.0 - Pain in throat, J20.9 - Acute bronchitis, unspecified,

Date of Onset : 28/14/2023

Requested Investigations: 9, Consultation GP, 94640, AIRWAY INHALATION TREATMENT, 0188-135906-2441, PULMICORT, 0006-124513-2071, VENTOLIN NEBULES

Estimated Cost :

Prescriptions: 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS, 0006-402804-2481 - (SALBUTAMOL (AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE), 0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 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 :

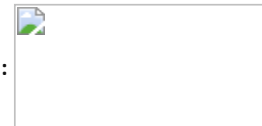
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : 28-Oct-2023

Signature :

Date : 28-Oct-2023