Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: GANGA KERUNG	**Service Date**	:01-Nov-2023
Card No	: I040-029-113718932-01	**Health Provider**	:Irham Medical Center Arjan
Policy Holder	: GANGA KERUNG	**Doctor's Name**	:Sajid Sanaullah
Payer Name	: UNION INSURANCE COMPANY	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 02-01-2023 To 01-01-2024		
Gender	: Male		
Date Of Birth	: 08-Oct-1981		
Patient's Tel No	: 0503621186		

Network : Green

Direct Access SP - YES

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

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : suspected case of fatty liver and low creatinine clearance, c/o low back pain, c/o heartburn **Duration:**

Vitals: Temp : 36.6 Bp :123 Pulse :76 Resp :22

Clinical Findings:

Diagnosis: K76.0 - Fatty (change of) liver, not elsewhere classified,K29.00 - Acute gastritis without bleeding,M54.5 - Low back pain, **Date of Onset** :01/19/2023

Requested Investigations: 84460, TRANSFERASE ALANINE AMINO ALT SGPT,84450, TRANSFERASE ASPARTATE AMINO AST SGOT,82565, CREATININE BLOOD,82575, CREATININE CLEARANCE,81000, URINALYSIS NONAUTO W/SCOPE,9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT **Estimated Cost** :

Prescriptions: 5944-174201-1451 - (OMEPRAZOLE : 20 MG) CAPSULES (HARD GELATIN),1394-143701-1453 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN), **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 : 01-Nov-2023

Signature :

Date : 01-Nov-2023