

Administrative

Patient Name : GANGA KERUNG

Card No : I040-029-113718932-01

Policy Holder : GANGA KERUNG

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2023 To 01-01-2024

Gender : Male

Date Of Birth : 08-Oct-1981

Patient's Tel No : 0503621186

MEDICAL CLAIM FORM

Service Date :01-Nov-2023

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Co-Insurance :

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

Remarks :

Claim Ref:

Network : Green

Direct Access SP - YES

☐ 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

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.

Dr's Name : Sajid Sanaullah

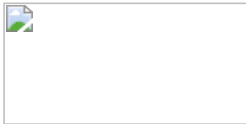
Signature :

Stamp :

Date : 01-Nov-2023

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.

Patient 's signature{Parent : if minor}

Date : Nov-2023