

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SUSHIL POUDEL GOVINDA
Card No : I040-029-119078847-01
Policy Holder : SUSHIL POUDEL GOVINDA
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2023 To 01-01-2024
Gender : Male
Date Of Birth : 26-Nov-1996
Patient's Tel No : 971563093585

Service Date : 01-Nov-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

Co-Insurance :

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : cough and headache
 Duration :

Vitals:Temp : 38.3 Bp :110 Pulse :100 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J20.9 - Acute bronchitis, unspecified,R05 - Cough,R52 - Pain, unspecified,R07.0 - Pain in throat,M54.5 - Low back pain,
 Date of Onset : 01/16/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO
 DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-149902-1021, CLOFEN ,0125-122107-1022,
 DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR
 INJECTION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%)
 (DEXTROSE : 5%) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT

Estimated :
Cost

Prescriptions: 1394-143701-1453 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),6960-116403-
 0061 - (AMOXICILLIN : 500 MG) CAPSULES,0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5
 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),1394-143701-1451 -
 (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),5944-174201-1451 - (OMEPRazole : 20 MG)
 CAPSULES (HARD GELATIN),2626-106616-2002 - (PARACETAMOL : 665MG) MODIFIED RELEASE
 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 :

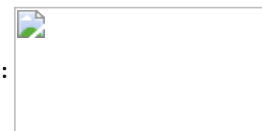
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : 01-Nov-2023

Signature :

Date : 01-Nov-2023