Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SHALIKA MADUWANTHI KULAWANSHA KARUNA PELIGE**
Card No	**: I040-029-119668661-01**
Policy Holder	**: SHALIKA MADUWANTHI KULAWANSHA KARUNA PELIGE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2023** To **01-01-2024**
Gender	**: Female**
Date Of Birth	**: 20-Feb-1996**
Patient's Tel No	**: 0561360824**

Service Date **:04-Nov-2023** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

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 :

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

Chief Complaints : High fever and chills and severe cough started three days ago on 1/11/2023 **Duration:** severe body pain and malaise started today

Vitals: Temp : 37.6 Bp :90 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R68.83 - Chills (without fever),R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing,J18.0 - Bronchopneumonia, unspecified organism, **Date of Onset** :04/17/2023

Requested Investigations: 9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-111805-1021, CHLOROHISTOL 10MG,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED **Estimated Cost** :

Prescriptions: 0005-116801-1162 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0097-116207-0391 - (AMOXICILLIN : 500 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 : 04-Nov-2023

Signature :

Date : 04-Nov-2023