

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SEKH ESTYAK ALI SEKH AKTHAR ALI
 Card No : I040-029-118843245-01
 Policy Holder : SEKH ESTYAK ALI SEKH AKTHAR ALI

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 20-Dec-1992

Patient's Tel No : 0528452339

Service Date :05-Nov-2023

Health Provider :Irham Medical Center Arjan

Doctor's Name :Enomen Goodluck

Network : Green

Direct Access SP - YES

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 : Still C/o; fever, headache, upper abdominal pain and 7 episodes of diarrhea **Duration:**

Pain is worse after a meal, radiates to the back with associated belching, flatulence, bloating and diarrhea. Had previously presented 5days ago and was managed as a case of acute upper respiratory infection and given medications including NSAID. NSAID induced gastritis suspected.

Vitals:Temp : 36.7 Bp :110 Pulse :90 Resp :24

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R10.13 - Epigastric pain,R19.7 - Diarrhea, unspecified,R14.0 - Abdominal distension (gaseous), **Date of Onset** :05/00/2023

Requested Investigations: 9.01, Follow Up Consultation GP,96360, HYDRATION IV INFUSION **Estimated :**
 INIT,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,0005-242802-0781, PANTONIX 40MG I.V.,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION **Cost**

Prescriptions: 0137-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

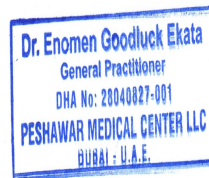
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

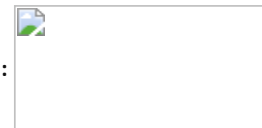
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



Date : Nov-2023

Signature :

Date : 05-Nov-2023