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 **:06-Nov-2023** **Network** **:** Green

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

Doctor's Name **:Enomen Goodluck**

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 : C/o: Fever, runny nose, coughing and chest pain. Also has shortness of breath and difficulty breathing, but not a previously known asthmatic. Also has pain in throat, nasal congestion and throbbing headache. Symptoms onset since 3days. Had previously presented 2days ago and was given medication but no relief. Now has also developed severe epigastric pain and tenderness. Husband tested positive to influenza A virus last week. Influenza suspected. **Duration:**

Vitals: Temp : 38.4 Bp :85 Pulse :104 Resp :24

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,J11.1 - Flu due to unidentified influenza virus w oth resp manifest,J00 - Acute nasopharyngitis [common cold],J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,R06.00 - Dyspnea, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding,R10.13 - Epigastric pain, **Date of Onset** :06/18/2023

Requested Investigations: 9.01, Follow Up Consultation GP,0005-149902-1021, CLOFEN ,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,0006-124513-2071, VENTOLIN NEBULES,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-111805-1021, CHLOROHISTOL 10MG,96360, HYDRATION IV INFUSION INIT,0005-242802-0781, PANTONIX 40MG I.V. **Estimated Cost** :

Prescriptions: 5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

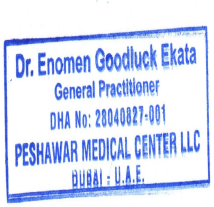
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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.

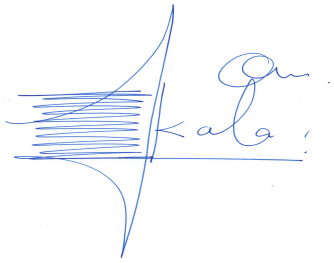
Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}

Date : 06-Nov-2023

Signature :  **Date :** 06-Nov-2023