Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHAMARA LAKMAL SRI RANAWAKA RANAWAKA ARACHCHIGE**
Card No	**: I040-029-118249220-01**
Policy Holder	**: CHAMARA LAKMAL SRI RANAWAKA RANAWAKA ARACHCHIGE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2023** To **01-01-2024**
Gender	**: Male**
Date Of Birth	**: 16-Sep-1995**
Patient's Tel No	**: 0544998349**

Service Date **:14-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 : gastroenteritis from 12/11/2023, from 7 days ago 7/11/2023 throat congested and infection , fever and vomiting **Duration:**

Vitals: Temp : 37 Bp :147 Pulse :111 Resp :24

Clinical Findings:

Diagnosis: A08.19 - Acute gastroenteropathy due to other small round viruses,J06.0 - Acute laryngopharyngitis, **Date of Onset :**14/24/2023

Requested Investigations: 96372, THER/PROPH/DIAG INJ SC/IM,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,9, Consultation GP **Estimated Cost :**

Prescriptions: 0252-107001-1171 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) 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 : 14-Nov-2023

Signature :

Date : 14-Nov-2023