Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ANNISA RAHIM**
Card No	**: I040-029-118989652-01**
Policy Holder	**: ANNISA RAHIM**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2023** To **01-01-2024**
Gender	**: Female**
Date Of Birth	**: 08-Aug-2002**
Patient's Tel No	**: 0581825119**

Service Date **:22-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 : from 20/11/23 has headache and sore throat **Duration :**

Vitals: Temp : 36.9 Bp :119 Pulse :77 Resp :22

Clinical Findings:

Diagnosis: J03.91 - Acute recurrent tonsillitis, unspecified,R05 - Cough,R51.9 - Headache, unspecified,J20.9 - Acute bronchitis, unspecified,J02.9 - Acute pharyngitis, unspecified, **Date of Onset** **:**22/42/2023

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV,0006-124513-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** **:**

Prescriptions: 0252-107001-1171 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) TABLETS,0248-135501-1161 - (DEXTROMETHORPHAN : 125 MG/100ML) (DIPHENHYDRAMINE : 100 MG/100ML) (EPHEDRINE : 150 MG/100 ML) (GUAIFENESIN : 10 MG/ML) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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 : 22-Nov-2023

Signature :

Date **:** 22-Nov-2023