Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NABIN KUMAR DAS**
Card No	**: I040-029-119613171-01**
Policy Holder	**: NABIN KUMAR DAS**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 10-07-2023** To **01-01-2024**
Gender	**: Male**
Date Of Birth	**: 03-May-1999**
Patient's Tel No	**: 0542219507**

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 15/11/2023 has low back pain **Duration** :

Vitals: Temp : 36.4 Bp :123 Pulse :66 Resp :22

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 22/10/2023

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **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