

## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

Patient Name : BERNADETTE LASCANO SANTOS  
 Card No : I040-029-113719036-01  
 Policy Holder : BERNADETTE LASCANO SANTOS

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Female

Date Of Birth : 18-Oct-1980

Patient's Tel No : 564877567

Service Date : 01-Dec-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 : severe vomiting since today in the morning 10 am 1/12/2023 severe stomach pain last period was last week

Duration:

Vitals:Temp : 36.2 Bp :124 Pulse :85 Resp :22

#### Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified, Date of Onset :01/59/2023

Requested Investigations: 9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0005-242802-0781, PANTONIX 40MG I.V.,0005-150403-1021, PREMOSAN ,96360, HYDRATION IV INFUSION INIT,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH

Estimated :

Cost

Prescriptions: 0435-189401-1113 - (CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION,0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM)) : 40 MG) DELAYED RELEASE TABLET,0031-168201-0391 - (DOMPERIDONE : 10 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 :

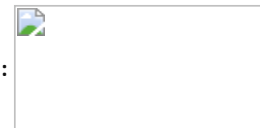
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



01-Date : Dec-2023

Signature :

Date : 01-Dec-2023