Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **BERNADETTE LASCANO SANTOS**	**Service Date**	:**01-Dec-2023**
Card No	: **I040-029-113719036-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **BERNADETTE LASCANO SANTOS**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2023** To **01-01-2024**		
Gender	: **Female**		
Date Of Birth	: **18-Oct-1980**		
Patient's Tel No	: **564877567**		

Network : Green

Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : coughing mostly dry for 2 days flu sneezing for 2 days fever occasional 1day, 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,J03.90 - Acute tonsillitis, unspecified,J01.80 - Other acute sinusitis, **Date of Onset** :01/03/2023

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,86140, C REACTIVE PROTEIN,85027, BLOOD COUNT COMPLETE AUTOMATED,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0006-124513-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION **Estimated Cost** :

Prescriptions: 1162-106616-2001 - (PARACETAMOL : 665MG) MODIFIED RELEASE TABLETS,2139-368007-3592 - (FLUTICASONE PROPIONATE : 0.05% W/W) SUSPENSION FOR NASAL SPRAY,0846-253101-1161 - (HEDERA HELIX (IVY) : 7MG/ML) SYRUP,0031-148701-1171 - (LORATADINE : 10 MG) TABLETS,0355-103201-0391 - (CIPROFLOXACIN : 500 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} :

Date : 01-Dec-2023

Signature :

Date : 01-Dec-2023