

Administrative**MEDICAL CLAIM FORM****Claim Ref:**

Patient Name : LIEZEL SUICO DESABILLE
Card No : I040-029-113719145-01
Policy Holder : LIEZEL SUICO DESABILLE
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2023 To 01-01-2024
Gender : Female
Date Of Birth : 19-Oct-1974
Patient's Tel No : 0567312820

Service Date :15-Dec-2023
Health Provider :Irham Medical Center Arjan
Doctor's Name :Sajid Sanaullah
Co-Insurance :

Network : Green
Direct Access SP - YES

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 sore throat and chilling since three days and high fever and sneezing Duration: since 12/12/2023 severe nasal congestion started today		
Vitals: Temp : 37.8 Bp :146 Pulse :96 Resp :22		
Clinical Findings:		
Diagnosis: J02.9 - Acute pharyngitis, unspecified,J20.9 - Acute bronchitis, unspecified,R68.83 - Chills (without fever),R50.9 - Fever, unspecified,R09.81 - Nasal congestion,		Date of Onset :15/59/2023
Requested Investigations: 0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0006-124513-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT,9, Consultation GP		Estimated Cost :
Prescriptions: 0027-128802-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) LIQUID FOR SPRAY (NASAL),0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 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

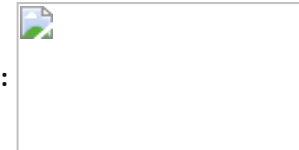
regarding my medical condition & history for purpose of
determining insurance benefits.

**Dr's
Name** : Sajid Sanaullah

Stamp :



**Patient 's
signature{Parent :
if minor}**



Date : 15-
Dec-
2023

Signature :



Date : 15-Dec-2023