Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHIGOZIE FRANCIS ONWUASOANYA**
Card No	**: I040-029-117072633-01**
Policy Holder	**: CHIGOZIE FRANCIS ONWUASOANYA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2023** To **01-01-2024**
Gender	**: Male**
Date Of Birth	**: 04-Sep-1990**
Patient's Tel No	**: 971555429234**

Service Date :23-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 : pain arround umblus and also pain in area of stomach, Fever chills, diarrhea **Duration:**

Vitals: Temp : 365.7 Bp :130 Pulse :76 Resp :21

Clinical Findings:

Diagnosis: R10.9 - Unspecified abdominal pain,K58.0 - Irritable bowel syndrome with diarrhea,R19.7 - Diarrhea, unspecified, **Date of Onset** :23/29/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1553-571101-0061 - (BIFIDOBACTERIUM LONGUM : 200000000 CFU) (LACTOBACILLUS GASSERI : 200000000 CFU) (BIFIDOBACTERIUM BIFIDUM : 200000000 CFU) CAPSULES,0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,0155-132303-1451 - (MEBEVERINE : 200 MG) CAPSULES (HARD GELATIN), **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 : 23-Dec-2023

Signature :

Date : 23-Dec-2023