

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 around umbilicus and also pain in area of stomach, Fever chills, diarrhea Duration:

Vitals:Temp : 36.5 Bp :130 Pulse :76 Resp :21

Clinical Findings:

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

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 :

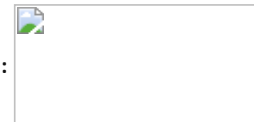
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2023

Signature :

Date : 23-Dec-2023