## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

| | |
|---|---|
| **Patient Name** | **: SEKH ESTYAK ALI SEKH AKTHAR ALI** |
| **Card No** | **: I040-029-118843245-01** |
| **Policy Holder** | **: SEKH ESTYAK ALI SEKH AKTHAR ALI** |
| **Payer Name** | **: UNION INSURANCE COMPANY** |
| **TPA** | **: E CARE - Blue Network** |
| **Validity** | **: 02-01-2024** To **01-01-2025** |
| **Gender** | **: Male** |
| **Date Of Birth** | **: 20-Dec-1992** |
| **Patient's Tel No** | **: 0528452339** |

**Service Date** :**03-Feb-2024** **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 :** C/o: Chest burning and repeated bupping and belching. Symptoms is worst after eating. **Duration:**

**Vitals:**Temp : 36.8 Bp :132 Pulse :82 Resp :22

**Clinical Findings:**

**Diagnosis:** K29.00 - Acute gastritis without bleeding,K21.00 - Gastro-esophageal reflux dis with esophagitis, without bleed, **Date of Onset** :04/33/2024

**Requested Investigations:** 96374, THER/PROPH/DIAG INJ IV PUSH,0005-242802-0781, PANTONIX 40MG I.V.,0005-136504-1021, SCOPINAL,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

**Prescriptions:** 0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,1267-141614-1112 - (ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION,0137-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC 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 :** 04-Feb-2024

**Signature :**

**Date** : 04-Feb-2024