Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AMIR BAHADUR BIST**	**Service Date**	**:06-Feb-2024**
Card No	**: I040-029-118843244-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: AMIR BAHADUR BIST**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**	**Remarks**	**:**
Validity	**: 02-01-2024** To **01-01-2025**		
Gender	**: Male**		
Date Of Birth	**: 27-Sep-1999**		
Patient's Tel No	**: 0569752337**		

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 : C/o: Low back pain since the past 3 days. Said to have started after carrying a heavy bed. Had a similar history 7months ago. Pain score is 7/10 **Duration:**

Vitals: Temp : 36.8 Bp :110 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M47.896 - Other spondylosis, lumbar region, **Date of Onset** :06/51/2024

Requested Investigations: 9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN **Estimated Cost** :

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0090-122303-0392 - (ETORICOXIB : 90 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 : 06-Feb-2024

Signature :

Date : 06-Feb-2024