Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CAROLINE WANJIKU**
Card No	**: I040-029-120121718-01**
Policy Holder	**: CAROLINE WANJIKU**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Female**
Date Of Birth	**: 03-Mar-1995**
Patient's Tel No	**: 0581745287**

Service Date **:07-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: Pruritic lesions sparsely but globally distributed on all parts of the body. **Duration:** Said to have first been noticed 2months ago. Exam: Lesions demonstrates central clearing with active margins.

Vitals: Temp : 36.8 Bp :124 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: B49 - Unspecified mycosis,L30.9 - Dermatitis, unspecified, **Date of Onset** **:**07/36/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** **:**

Prescriptions: **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 : 07-Feb-2024

Signature :

Date **:** 07-Feb-2024