

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JEET BAHADUR KHATRI

Card No : I040-029-120209240-01

Policy Holder : JEET BAHADUR KHATRI

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Male

Date Of Birth : 02-Aug-1980

Patient's Tel No : 0504753940

Service Date :08-Feb-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Network : Green

Direct Access SP - YES

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 : Recurrent cough for the past 8months, especially on cold mornings. Also now has chest pain. Does not smoke and he is not a known asthmatic. Chest: Clinically clear. Chest X-ray is advised.

Duration:**Vitals:**Temp : 36.8 Bp :160 Pulse :86 Resp :20**Clinical Findings:**

Diagnosis: J45.21 - Mild intermittent asthma with (acute) exacerbation,J20.9 - Acute bronchitis, unspecified,J02.9 - Acute pharyngitis, unspecified,J00 - Acute nasopharyngitis [common cold],

Date of Onset :08/54/2024

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated : Cost

Prescriptions: 0005-124508-1173 - (SALBUTAMOL : 2 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0090-265901-1171 - (MONTELUKAST : 10 MG) 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 :

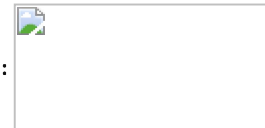
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Feb-2024

Signature :

Date : 08-Feb-2024