Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MARIA CARLA MAE**	**Service Date**	:**09-Feb-2024**
Card No	: **I040-029-120319772-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **MARIA CARLA MAE**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Validity**	: **15-01-2024** To **14-01-2025**
Gender	: **Female**	**Remarks**	:
Date Of Birth	: **04-May-1988**		
Patient's Tel No	: **0521230675**		

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: Cough that is dry, associated with chest pain, and right shoulder and back pain. Symptoms started since the past 3days. There is also fever and headache. Adopted a cat 4months ago. Smokes tobacco and uses vape. Not a known hypertensive, and not diabetic but has PCOS

Duration:

Vitals: Temp : 36.7 Bp :120 Pulse :72 Resp :22

Clinical Findings:

Diagnosis: J45.20 - Mild intermittent asthma, uncomplicated,J20.9 - Acute bronchitis, unspecified,A28.1 - Cat-scratch disease,

Date of Onset :09/53/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED

Estimated Cost :

Prescriptions: 0090-265901-1171 - (MONTELUKAST : 10 MG) TABLETS,1161-274301-0392 - (LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS,1111-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0005-119803-1171 - (PREDNISOLONE : 20 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 : 09-Feb-2024

Signature :

Date : 09-Feb-2024