

## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

Patient Name : MONICA RAM DATT SHARMA  
Card No : I040-029-117518711-01  
Policy Holder : MONICA RAM DATT SHARMA

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Female

Date Of Birth : 16-Mar-1995

Patient's Tel No : 0509706442

Service Date :17-Feb-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Sajid Sanaullah

Co-Insurance :

|              |               |        |           |     |           |        |
|--------------|---------------|--------|-----------|-----|-----------|--------|
| CONSULTATION | LAB/RADIOLOGY | PHYSIO | PHARMACY  | IP  | MATERNITY | DENTAL |
| 10% max      | NIL           | NIL    | NIL LIMIT | NIL | 10%       | NA     |

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

**Chief Complaints :** C/o: Fever, pain in throat and cough with chest pain. Symptoms started 3days ago. and relieved transiently by pcm. No known allergies no other known medical conditions. Not asthmatic. ENT: hyperemic pharynx.

**Vitals:**Temp : 36.6 Bp :113 Pulse :75 Resp :22

**Clinical Findings:**

**Diagnosis:** J02.8 - Acute pharyngitis due to other specified organisms,J00 - Acute nasopharyngitis [common cold],J30.9 - Allergic rhinitis, unspecified,J20.9 - Acute bronchitis, unspecified,

**Date of Onset** :17/23/2024

**Estimated Cost** :

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),5253-649501-3851 - (MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 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 :**

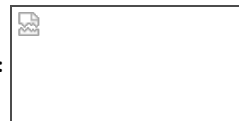
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient 's signature{Parent : if minor}



Date : 17-Feb-2024

Signature :

Date : 17-Feb-2024