Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MONICA RAM DATT SHARMA**	**Service Date**	:**17-Feb-2024**
Card No	: **I040-029-117518711-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **MONICA RAM DATT SHARMA**	**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	: **Female**		
Date Of Birth	: **16-Mar-1995**		
Patient's Tel No	: **0509706442**		

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: 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. **Duration:**

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