Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **HASEEB LODHI GHAZANFAR MEHMOOD**	**Service Date**	:**18-Feb-2024**
Card No	: **I040-029-117681852-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **HASEEB LODHI GHAZANFAR MEHMOOD**	**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	: **Male**		
Date Of Birth	: **06-Dec-1995**		
Patient's Tel No	: **0521005291**		

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 ANAL BLEEDING SINCE 2 MONTHS ,RECURRENT EPISODES IBUPROFEN ALLERGY **Duration:**

Vitals:

Clinical Findings:

Diagnosis: K62.5 - Hemorrhage of anus and rectum, **Date of Onset** : 18/48/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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 : 18-Feb-2024

Signature :

Date : 18-Feb-2024