Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SONU VISHWAKARMA**
Card No	**: I040-029-118690228-01**
Policy Holder	**: SONU VISHWAKARMA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 10-Dec-1990**
Patient's Tel No	**: 0528376423**

Service Date **:19-Feb-2024** **Network** **:** Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Sajid Sanaullah**

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 : C/O TRAUMA TO FINGER OF RIGHT HAND ,THERE IS OPEN WOUND THAT NEEDS SUTURING WOUND SIZE IS APPROXIMATELY 5CM X2CMX2CM PLAN OF CARE CLEAN THE WOUND SUTURE WOUND DRESSING FOR 5 DAYS **Duration:**

Vitals: Temp : 36.5 Bp :145 Pulse :95 Resp :22

Clinical Findings:

Diagnosis: L08.9 - Local infection of the skin and subcutaneous tissue, unsp,Z48.00 - Encounter for change or removal of nonsurg wound dressing, **Date of Onset** **:**19/19/2024

Requested Investigations: 9, Consultation GP,51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** **:**

Prescriptions: 0005-252201-0391 - (CAFFEINE : 65 MG) (IBUPROFEN : 400 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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 : 19-Feb-2024

Signature :

Date **:** 19-Feb-2024