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 **:20-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 : For follow up and wound dressing change. Nil fresh complaint. has mild pain. **Duration:**

Vitals:

Clinical Findings:

Diagnosis: Z48.00 - Encounter for change or removal of nonsurg wound dressing, **Date of Onset** **:**20/32/2024

Requested Investigations: 51.03, Non-surgical cleansing with surgical dressing more than 48 sq inches / 300 sq centimeters,9.01, Follow Up Consultation GP **Estimated Cost** **:**

Prescriptions: **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 :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} **:** **Date :** 20-Feb-2024

Signature : **Date** **:** 20-Feb-2024