

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SEKH ESTYAK ALI SEKH AKTHAR ALI
Card No : I040-029-118843245-01
Policy Holder : SEKH ESTYAK ALI SEKH AKTHAR ALI

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 20-Dec-1992

Patient's Tel No : 0528452339

Service Date :12-Mar-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Enomen Goodluck

Network : Green

Direct Access SP - YES

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: pain in the right flank since yesterday. associated with nausea and vomiting and constipation but there is no fever. Duration:

Vitals:Temp : 36.8 Bp :114 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: N20.2 - Calculus of kidney with calculus of ureter,M54.5 - Low back pain,K59.00 - Constipation, unspecified, Date of Onset :12/00/2024

Requested Investigations: 9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT

Estimated :
Cost

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0027-149906-1171 - (DICLOFENAC SODIUM : 25 MG) TABLETS,1356-111705-0251 - (SODIUM CITRATE : 630 MG) (TARTARIC ACID : 890 MG) (SODIUM BICARBONATE : 1.76G) (CITRIC ACID : 720 MG) EFFERVESCENT GRANULES,0481-382801-0391 - (PRUCALOPRIDE (AS PRUCALOPRIDE SUCCINATE) : 1 MG) FILM COATED TABLETS,0240-223401-1171 - (NAPROXEN : 500 MG) TABLETS,0042-136501-1173 - (HYOSCINE : 10 MG) TABLETS,

Estimated :
Cost

MEDICAL PRACTITIONER DECLARATION :

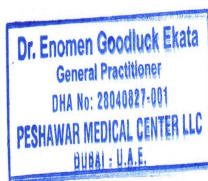
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

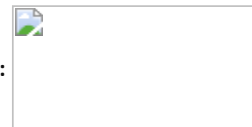
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



12-
Date : Mar-
2024

Signature :

Date : 12-Mar-2024