

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SUSHIL POUDEL GOVINDA
Card No : I040-029-119078847-01
Policy Holder : SUSHIL POUDEL GOVINDA
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2024 To 01-01-2025
Gender : Male
Date Of Birth : 26-Nov-1996
Patient's Tel No : 0559627904

Service Date : 26-Mar-2024
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck

Network : Green
Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Co-Insurance :

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : Kneel joint pains on both lower limbs. Pain is worst in the mornings on waking. No history of trauma. Associated lower back pain. Works as a house keeper in the hotel and job is stressful Counselling on the need for weight loss.

Vitals: Temp : 37.1 Bp :120 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: M17.0 - Bilateral primary osteoarthritis of knee,M47.896 - Other spondylosis, lumbar region,M54.5 - Low back pain,

Date of Onset : 26/56/2024

Requested Investigations: 9, Consultation GP

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0090-122303-0392 - (ETORICOXIB : 90 MG) FILM COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

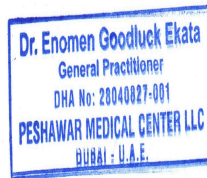
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

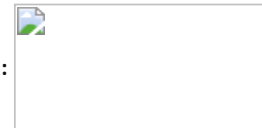
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



26-
Date : Mar-2024

Signature :

Date : 26-Mar-2024