Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **LIEZEL SUICO DESABILLE**	**Service Date**	:**29-Mar-2024**
Card No	: **I040-029-113719145-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **LIEZEL SUICO DESABILLE**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Female**		
Date Of Birth	: **19-Oct-1974**		
Patient's Tel No	: **0567312820**		

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: Cough and wheezing. A known asthamatic. Does not have fever. **Duration :**

Vitals: Temp : 36.7 Bp :149 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J45.21 - Mild intermittent asthma with (acute) exacerbation,R05 - Cough, **Date of Onset** :29/08/2024

Requested Investigations: 9, Consultation GP,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT **Estimated Cost** :

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0090-265901-1171 - (MONTELUKAST : 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.

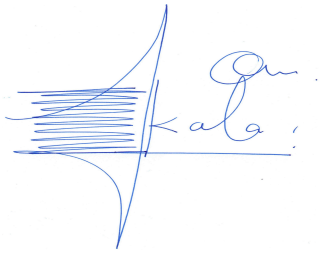
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent : if minor}

Date : 29-Mar-2024

Signature :



Date : 29-Mar-2024