

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHIGOZIE FRANCIS
ONWUASOANYA
Card No : I040-029-117072633-01
Policy Holder : CHIGOZIE FRANCIS
ONWUASOANYA

Payer Name : UNION INSURANCE
COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 04-Sep-1990

Patient's Tel No : 971555429234

Service Date :12-Apr-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 throat and nasal congestion with runing nose.

Duration :

Vitals:Temp : 36.6 Bp :120 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified,

Date of Onset :12/26/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED

Estimated :

TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG)

Cost

(PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,

MEDICAL PRACTITIONER DECLARATION :

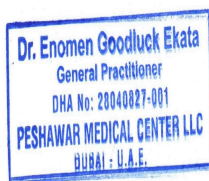
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Apr- 2024

Signature :

Date : 12-Apr-2024