Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **DEO . MUYANJA**	**Service Date**	:**23-Apr-2024**
Card No	: **I040-029-117038318-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **DEO . MUYANJA**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **18-Dec-1985**		
Patient's Tel No	: **0521897638**		

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 : co fungal infection 3 days on foot corns on the sole of the right feet oe fungal patch on left foot corns on his right foot sole chest clear vitals are stable **Duration:**

Vitals: Temp : 36.5 Bp :123 Pulse :95 Resp :18

Clinical Findings:

Diagnosis: B49 - Unspecified mycosis,L84 - Corns and callosities, **Date of Onset** : 23/07/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

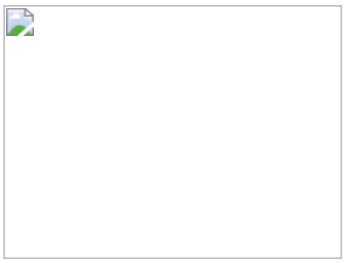
Prescriptions: 0009-148801-0151 - (KETOCONAZOLE : 2%) CREAM,0195-140201-1451 - (FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN), **Estimated Cost** :

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 : Humaira **Stamp :** 

Patient 's signature{Parent if minor} :  **Date** : 23-Apr-2024

Signature :  **Date** : 23-Apr-2024