Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MARK OLIVER DELA CRUZ MENDOZA**	**Service Date**	:**27-Apr-2024**
Card No	: **I040-029-115456011-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **MARK OLIVER DELA CRUZ MENDOZA**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-07-2023** To **30-06-2024**		
Gender	: **Male**		
Date Of Birth	: **18-Feb-1989**		
Patient's Tel No	: **0566079559**		

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: Recurrent weakness and tiredness Give Ramandan Package **Duration :**

Vitals: Temp : 37 Bp :128 Pulse :73 Resp :22

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,E55.9 - Vitamin D deficiency, unspecified,Q61.2 - Polycystic kidney, adult type,R53.1 - Weakness,

Date of Onset :27/00/2024

Requested Investigations: 9, Consultation GP,101, GENARAL WELNES CHECKUP (55 TEST)

Estimated Cost :

Prescriptions: 0349-106203-1171 - (MULTIVITAMINS : 30 MG) (MINERALS : 30 MG) TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

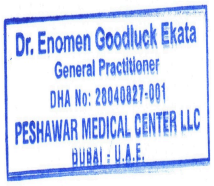
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

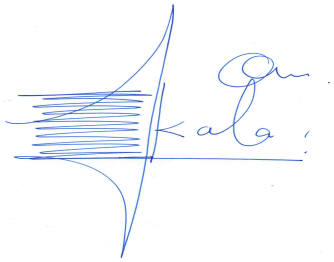
Stamp :



Patient 's signature{Parent if minor} :

Date : 27-Apr-2024

Signature :



Date : 27-Apr-2024