UCAF 2.0

To be completed & ID Verified by the reception/nurse:

Provider Name: Norman Jhon

Insurance Company Name: HDFC ERGO

TPA Company Name: HDFC ERGO

Patient File Number: PAT-A-0000694

Dept: Cardiology

Single (✔) Married ( )

Plan Type ( )

New Visit (✔) Follow Up ( ) Refill ( ) Walk In ( ) Referal ( )

Print/Fill in clear letters or Emboss Card:

Insured Name: HDFC ERGO

ID.Card No.: CARD00191334 Sex: Age: Y

Policy Holder:

Policy Number: 9098765

Expiry Date: 2020-12-31

Class:

Approval:

To be completed by the Attending Physician: Please Tick (✔)

Inpatient ( ) Outpatient (✔) Emergency Case (✔)

Emergency Care Level 1( ) | 2( ) | 3( )

BP: 180.00/120.00 Pulse: 84.00 bpm Temp: 100.00 °C Weight: 100.00 Kg Height: 100.00 cm RR: 100.00 Duration Of Illness: 0.00 (days)

Chief Complaint and Main Symptoms: Back Pain has pain as no hurts

Significant Signs:

Other Conditions:

Diagnosis: Dependence on aspirator,

Principal Code: Z99.0 2nd Code: 3rd Code: 4th Code:

Please tick (✔) where appropriate

Chronic ( ) Congenital ( ) RTA ( ) Work Related ( ) Vaccination ( ) Check-Up ( )

Psychiatric ( ) Infertility ( ) Pregnancy ( ) Indicate LMP ( )

Suggestive line (s) of management: Kindly, enumerate the recommended investigation, and / orprocedures For outpatient approval only:

Code	Description/Service	Type	Quantity	Cost
2412-7794-001	Norman-Consultation	Consultation	1.00	300.00
P57-6055-02211-01	Complete blood count (CBC)	Lab	1.00	75.00
P66-6085-06279-01	17-Hydroxy-Pregnenolone	Lab	1.00	75.00

Provider's Approval/Coding Staff must review/code the recommended service(s) and allocate cost and complete the following:

Completed/Coded By ..... Signature ..... Date .....

Medication Name (Generic Name)	Type	Quantity
Cetirizine 5 mg/5 ml Oral Solution		20.00

Is Case Management From (CMFI.0) Included Yes ( ) | No (✔)

Please Specify Possible line of Management When Applicable:

Estimated Length of Stay: **Days**

Expected Date of Admission:

I hereby certify that ALL information mentioned are correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Norman Jhon

Signature and Stamp

I hereby certify that all statements and information provided concerning patient Identification and the present illness or injury are TRUE.

Name and Relationship(if Guardian) Signature :

For Insurance Company Use Only: Approved: ( ) Not Approved: ( ) Approval No: Approval validity: Days

Comments (include approved days/services if different from the requested):

Approved/Disapproved By: Signature: ..... Date