Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHARLENE RAMSAMY**	**Service Date**	**:02-May-2024**
Card No	**: I022-029-118918862-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: CHARLENE RAMSAMY**	**Doctor's Name**	**:Humaira**
Payer Name	**: TAKAFUL EMARAT**		
TPA	**: E CARE - Blue Network**		
Validity	**: 16-10-2023** To **15-10-2024**		
Gender	**: Female**		
Date Of Birth	**: 30-Jul-1980**		
Patient's Tel No	**: 0557230485**		

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 : co left ear pain pus in ear cough throat pain fever oe chest is clear noadded sounds pus is coming out though the ear **Duration:**

Vitals: Temp : 36.8 Bp :136 Pulse :109 Resp :22

Clinical Findings:

Diagnosis: H66.92 - Otitis media, unspecified, left ear,R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified, **Date of Onset** :02/08/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-119805-1171 - (PREDNISOLONE : 5 MG) TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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 : Humaira **Stamp :** 

Patient 's signature{Parent if minor} :  **Date :** 02-May-2024

Signature :  **Date** : 02-May-2024