

Administrative

Patient Name : CHARLENE RAMSAMY

Card No : I022-029-118918862-01

Policy Holder : CHARLENE RAMSAMY

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

MEDICAL CLAIM FORM

Service Date :03-May-2024

Health Provider :Irham Medical Center Arjan

Doctor's Name :Humaira

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Claim Ref:

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints :Duration :

Vitals:

Clinical Findings:

Diagnosis: H66.92 - Otitis media, unspecified, left ear,R50.9 - Fever, unspecified,I06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,

Date of Onset :03/21/2024

Requested Investigations: 9.01, Follow Up Consultation GP,2190-106618-1001, PARAFUSIV,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH

Estimated Cost :

Prescriptions:

Estimated Cost :

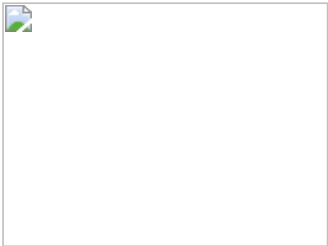
MEDICAL PRACTITIONER DECLARATION :
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Humaira

Stamp :



Signature :



Date : 03-May-2024

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.

Patient 's signature{Parent : if minor}



Date : May-2024

https://irhamc.visionsoftw ares.ae/mr_ecare_claim_print.aspx?appld=47948&patId=39962

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