Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **CHARLENE RAMSAMY**	**Service Date**	:**03-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 : **Duration** :

Vitals:

Clinical Findings:

Diagnosis: H66.92 - Otitis media, unspecified, left ear,R50.9 - Fever, unspecified,J06.9 - 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 : 03-May-2024