## Administrative

# MEDICAL CLAIM FORM

## Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **SONAM MANISHKUMAR VAZA** | **Service Date** | **:07-May-2024** |
| **Card No** | : **I022-029-120724591-01** | **Health Provider** | **:Irham Medical Center Arjan** |
| **Policy Holder** | : **SONAM MANISHKUMAR VAZA** | **Doctor's Name** | **:Humaira** |
| **Payer Name** | : **TAKAFUL EMARAT** | **Co-Insurance** | : |
| **TPA** | : **E CARE - Blue Network** | **Remarks** | : |
| **Validity** | : **29-04-2024** To **28-04-2025** | | |
| **Gender** | : **Female** | | |
| **Date Of Birth** | : **28-Nov-1987** | | |
| **Patient's Tel No** | : **0522082823** | | |

**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 :** co burning micturation dark colour urine dribbling of the urine oe chest is clear no added sounds vitals stable **Duration:**

**Vitals:**Temp : 37.4 Bp :141 Pulse :94 Resp :22

**Clinical Findings:**

**Diagnosis:** N39.0 - Urinary tract infection, site not specified,N39.43 - Post-void dribbling, **Date of Onset** :07/16/2024

**Requested Investigations:** 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

**Prescriptions:** 0097-658501-0251 - (TARTARIC ACID : 0.89G) (SODIUM BICARBONATE : 1.76G) (CRANBERRY EXTRACT : 0.25 G) (TRI SODIUM CITRATE ANHYDROUS : 0.63G) (CITRIC ACID ANHYDROUS : 0.72G) EFFERVESCENT GRANULES,0248-187801-1171 - (DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS,6076-482003-0392 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED 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

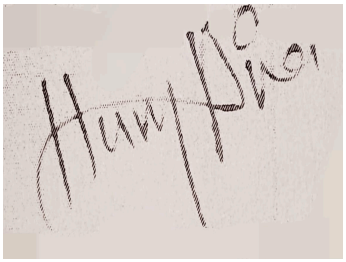
**Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

**Patient 's signature{Parent if minor}** :

**Date** : 07-May-2024

**Signature :**



**Date** : 07-May-2024