Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Mansoor Ali Yameen Ali**	**Service Date**	:**08-May-2024**
Card No	: **I040-029-113719090-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **Mansoor Ali Yameen Ali**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **25-Sep-1985**		
Patient's Tel No	: **0502245460**		

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 : Known hypertensive and diabetic. CO HEADACHE refill the medicine **Duration :**

Vitals: Temp : 37 Bp :145 Pulse :97 Resp :22

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,E78.2 - Mixed hyperlipidemia,R51.9 - Headache, unspecified, **Date of Onset :**08/06/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0095-238001-0171 - (DICLOFENAC ACID : 46.5MG) DISPERSIBLE TABLETS,0688-211505-0391 - (FENOFIBRATE : 145 MG) FILM COATED TABLETS,0252-155401-0391 - (LOSARTAN POTASSIUM : 50 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

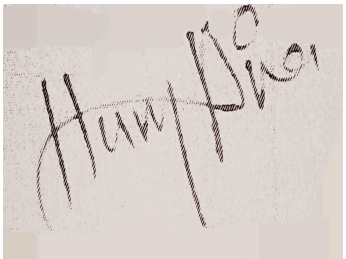
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 08-May-2024

Signature :



Date : 08-May-2024