Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ABHISHEK SHRESTHA . SHRESTHA**
Card No	**: I040-029-120481043-01**
Policy Holder	**: ABHISHEK SHRESTHA . SHRESTHA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 25-Jun-1997**
Patient's Tel No	**: 0545624507**

Service Date **:11-May-2024** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Humaira**

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 alllergy both hands and arm oe arm reddish itching all over the body chest is clear **Duration:**

Vitals: Temp : 37.1 Bp :146 Pulse :77 Resp :20

Clinical Findings:

Diagnosis: L29.9 - Pruritus, unspecified,R21 - Rash and other nonspecific skin eruption, **Date of Onset** :11/10/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0005-119805-1173 - (PREDNISOLONE : 5 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.

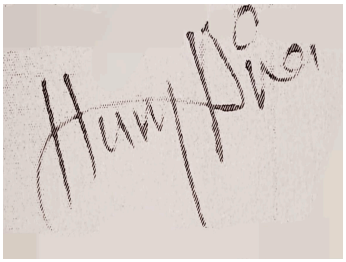
Dr's Name : Humaira

Stamp :

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

Patient 's signature{Parent if minor} :

Date : 11-May-2024

Signature : 

Date : 11-May-2024