Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MA RUBIETHA SOBERANO ALPES**	**Service Date:**	**15-May-2024**
Card No	: **I020-029-119436583-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **MA RUBIETHA SOBERANO ALPES**	**Doctor's Name**	**:Humaira**
Payer Name	: **AL-BUHAIRA NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-02-2024** To **31-01-2025**		
Gender	: **Female**		
Date Of Birth	: **01-Jan-1984**		
Patient's Tel No	: **509412509**		

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 weakness dizzzyness lethargy gaining fat 1 month oe dizzzy cheat isw clear no addded sounds stable **Duration:**

Vitals:

Clinical Findings:

Diagnosis: E78.5 - Hyperlipidemia, unspecified,I10 - Essential (primary) hypertension,R52 - Pain, unspecified, **Date of Onset :**15/50/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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

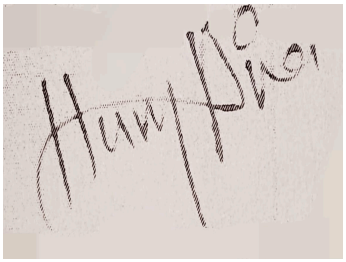
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 15-May-2024

Signature :



Date : 15-May-2024