Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**MUBASHIRA USSABRAHIM**
Card No	**I022-029-120325441-01**
Policy Holder	**MUBASHIRA USSABRAHIM**
Payer Name	**TAKAFUL EMARAT**
TPA	**E CARE - Green Network**
Validity	**14-01-2024** To **13-01-2025**
Gender	**Female**
Date Of Birth	**12-Oct-2001**
Patient's Tel No	**0526916526**

Service Date :15-May-2024 **Network** : Green

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

Doctor's Name :Enomen Goodluck

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 : C/o: pain in throat, cough and fever. All symptoms started yesterday night. headache, nasal congestion, there is no chest pain, no abdominal pain and no other complaint. There is no other past medical condition. LMP: 27/04/2024. **Duration:**

Vitals: Temp : 38.2 Bp :123 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J02.9 - Acute pharyngitis, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :15/57/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0070-148701-1171 - (LORATADINE : 10 MG) TABLETS,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 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.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature :

Date : 15-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 : 15-May-2024