Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Surendra Kumar Chaudhri**	**Service Date**	:**16-May-2024**
Card No	: **I040-029-117537322-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **Surendra Kumar Chaudhri**	**Doctor's Name**	:**Enomen Goodluck**
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	: **18-Apr-1988**		
Patient's Tel No	: **0522963916**		

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 : For follow up: A case of anal fissure, CBC report shows leukocytosis. Ishioanal abscess suspected. Incision and drainage advised **Duration:**

Vitals: Temp : 36.5 Bp :117 Pulse :79 Resp :18

Clinical Findings:

Diagnosis: K61.39 - Other ischiorectal abscess,K60.0 - Acute anal fissure,D72.829 - Elevated white blood cell count, unspecified, **Date of Onset** :16/43/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,0067-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0046-149903-2231 - (DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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 : 16-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 : 16-May-2024