Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **CHIGOZIE FRANCIS ONWUASOANYA**	**Service Date**	:**17-May-2024**
Card No	: **I040-029-117072633-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **CHIGOZIE FRANCIS ONWUASOANYA**	**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	: **04-Sep-1990**		
Patient's Tel No	: **971555429234**		

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 lower abdominal pain dark colour urine 2 weeks ago oe chest is clear no addded sounds epigastric and lower abdominal pain vitals stable **Duration:**

Vitals: Temp : 36.8 Bp :100 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: K29.70 - Gastritis, unspecified, without bleeding,R52 - Pain, unspecified,R19.7 - Diarrhea, unspecified, **Date of Onset:**17/54/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,80069, RENAL FUNCTION PANEL,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost :**

Prescriptions: 6445-533801-1561 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES,0102-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0248-187801-1171 - (DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 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

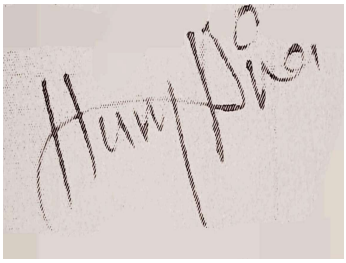
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 17-May-2024

Signature :



Date : 17-May-2024