Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **GIRIDHAR DUGGENA**
Card No	: **I005-029-115888608-01**
Policy Holder	: **GIRIDHAR DUGGENA**
Payer Name	: **DUBAI INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **25-08-2023** To **24-08-2024**
Gender	: **Male**
Date Of Birth	: **08-Nov-1980**
Patient's Tel No	: **0527414425**

Service Date :**21-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 fever knee pain 2 days ago history of fall oe muscle strain chest is clear no **Duration:** added sounds vitals stable

Vitals: Temp : 37.8 Bp :134 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,M62.838 - Other muscle spasm,R52 - Pain, unspecified,M25.462 - Effusion, left knee,K29.70 - Gastritis, unspecified, without bleeding, **Date of Onset** :21/28/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0248-187801-1171 - (DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS,0207-142902-1451 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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

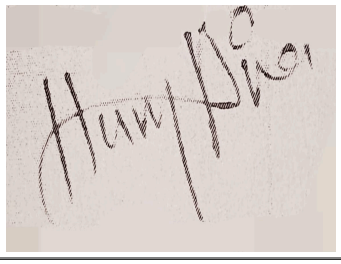
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 21-May-2024

Signature :



Date : 21-May-2024