Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: BALVIR KUMAR KUMAR**
Card No	**: I005-029-115888573-01**
Policy Holder	**: BALVIR KUMAR KUMAR**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 25-08-2023** To **24-08-2024**
Gender	**: Male**
Date Of Birth	**: 06-Dec-1978**
Patient's Tel No	**: 0509842734**

Service Date **:23-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 pain in throat nausea skin rash 5 days oe chest is clear no addded sounds high grade fever history of insect bite co fever pain in throat nausea 2 days oe chest is clear no added sounds restless history of insect bite **Duration:**

Vitals: Temp : 38.2 Bp :123 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.90 - Acute tonsillitis, unspecified,K29.70 - Gastritis, unspecified, without bleeding,S00.96XS - Insect bite (nonvenomous) of unsp part of head, sequela, **Date of Onset** **:**23/22/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9.01, Follow Up Consultation GP,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,96360, HYDRATION IV INFUSION INIT **Estimated : Cost**

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 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

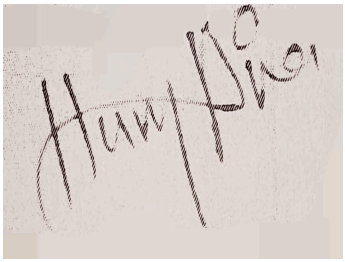
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 23-May-2024

Signature :



Date : 23-May-2024