Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: BALVIR KUMAR KUMAR	**Service Date**	:24-May-2024
Card No	: I005-029-115888573-01	**Health Provider**	:Irham Medical Center Arjan
Policy Holder	: BALVIR KUMAR KUMAR	**Doctor's Name**	:Humaira
Payer Name	: DUBAI INSURANCE COMPANY	**Co-Insurance**	
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 25-08-2023 To 24-08-2024		
Gender	: Male		
Date Of Birth	: 06-Dec-1978		
Patient's Tel No	: 0509842734		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,K29.70 - Gastritis, unspecified, without bleeding,S00.96XS - Insect bite (nonvenomous) of unsp part of head, sequela, **Date of Onset** :24/56/2024

Requested Investigations: 9.01, Follow Up Consultation GP,2190-106618-1001, PARAFUSIV,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: **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

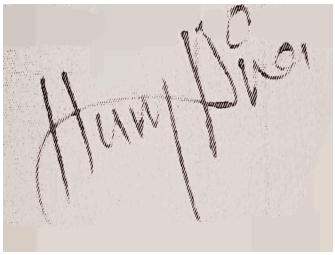
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 24-May-2024

Signature :



Date : 24-May-2024