Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AKASH RAJENDRAN RAJENDRAN**
Card No	**: I005-029-120621507-01**
Policy Holder	**: AKASH RAJENDRAN RAJENDRAN**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 21-03-2024** To **24-08-2024**
Gender	**: Male**
Date Of Birth	**: 28-Jun-2000**
Patient's Tel No	**: 0562958953**

Service Date **:25-May-2024** **Network** **:** Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

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 : Fever, generalized body pains, vomiting, Had previously presented 3days ago and was manged as a case of tonsillitis, fever however has persisted with body pains also. ALso has dizziness for every little task and thus has been unable to go to work. **Duration:**

Vitals: Temp : 37.7 Bp :118 Pulse :75 Resp :20

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R11.10 - Vomiting, unspecified,M79.18 - Myalgia, other site, **Date of Onset** **:**25/37/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,9.01, Follow Up Consultation GP **Estimated Cost :**

Prescriptions: 0005-150407-1172 - (METOCLOPRAMIDE : 10 MG) TABLETS,1516-107902-1171 - (IBUPROFEN : 400 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.

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 **:** Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent if minor} : **Date :** 25-May-2024

Signature : **Date** **:** 25-May-2024