

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 **Duration:** 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.

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 :

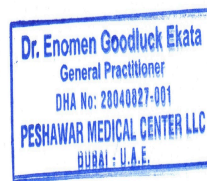
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

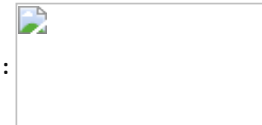
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's
signature{Parent :
if minor}



25-
Date : May-
2024

Signature :

Date : 25-May-2024