Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ISLAM HAFSI**	**Service Date**	:**01-Jun-2024**
Card No	: **I022-029-120338346-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **ISLAM HAFSI**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **17-01-2024** To **16-01-2025**		
Gender	: **Female**		
Date Of Birth	: **07-Oct-1988**		
Patient's Tel No	: **0521706901**		

Network : Green

Direct Access SP - YES

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 : **Duration** :

Vitals: Temp : 37.2 Bp :101 Pulse :63 Resp :18

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified,B65.3 - Cercarial dermatitis,L29.9 - Pruritus, unspecified, **Date of Onset** :01/27/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

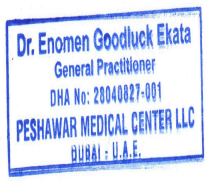
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Enomen Goodluck

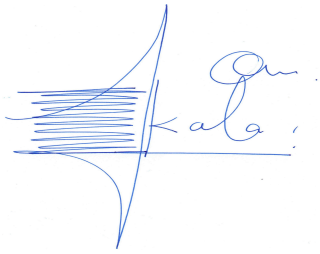
Stamp :



Patient 's signature{Parent : if minor}

Date : 01-Jun-2024

Signature :



Date : 01-Jun-2024