Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RAMESH BAIRI GANGADAS BAIRI**
Card No	**: I005-029-119881442-01**
Policy Holder	**: RAMESH BAIRI GANGADAS BAIRI**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 25-08-2023** To **24-08-2024**
Gender	**: Male**
Date Of Birth	**: 05-Nov-2003**
Patient's Tel No	**: 0562490216**

Service Date **:02-Jun-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 : **Duration** **:**

Vitals: Temp : 39.3 Bp :108 Pulse :111 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** **:** 02/21/2024

Requested Investigations: **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

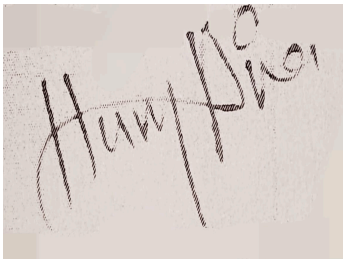
Stamp :

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

Patient 's signature{Parent if minor} **:**

Date : 02-Jun-2024

Signature :



Date **:** 02-Jun-2024