Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SONAM MANISHKUMAR VAZA**	**Service Date**	:**02-Jun-2024**
Card No	: **I022-029-120724591-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **SONAM MANISHKUMAR VAZA**	**Doctor's Name**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **29-04-2024** To **28-04-2025**		
Gender	: **Female**		
Date Of Birth	: **28-Nov-1987**		
Patient's Tel No	: **0522082823**		

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: Temp : 36.4 Bp :128 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** : 02/11/2024

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

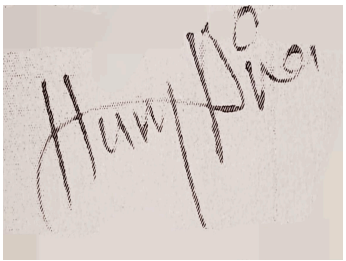
Stamp :

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