Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: TAMER TAREK MOHAMED SHATA**
Card No	**: I005-029-120832894-01**
Policy Holder	**: TAMER TAREK MOHAMED SHATA**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 17-05-2024** To **25-07-2024**
Gender	**: Male**
Date Of Birth	**: 10-Apr-1997**
Patient's Tel No	**: 0528896952**

Service Date **:05-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 : fever bodyache headache vomitting nausea 1 day oe chest is clear no added **Duration:** sounds restless

Vitals: Temp : 38.4 Bp :111 Pulse :113 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R51.9 - Headache, unspecified,R11.10 - Vomiting, unspecified, **Date of Onset** **:**05/19/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION **Estimated Cost :**

Prescriptions: 0097-397801-0392 - (DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0067-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0219-142902-1451 - CEFIXIME, **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

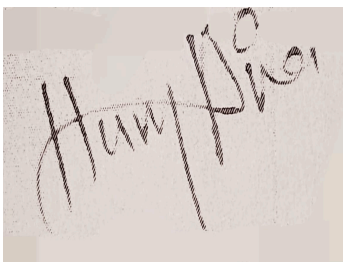
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 05-Jun-2024

Signature :



Date **:** 05-Jun-2024