Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ABDUL GHAFFAR MUNIR AHMAD**	**Service Date**	**:08-Jun-2024**
Card No	: **I040-029-120695866-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **ABDUL GHAFFAR MUNIR AHMAD**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **30-03-2024** To **29-03-2025**		
Gender	: **Male**		
Date Of Birth	: **22-Apr-1977**		
Patient's Tel No	: **0582760221**		

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 : PC: Bilateral swollen legs and abdominal distension. Exam: pitting pedal edema upto kneel joint. Plan: Refer to specialist internal medicine. **Duration:**

Vitals: Temp : 37 Bp :150 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: I50.33 - Acute on chronic diastolic (congestive) heart failure,K76.9 - Liver disease, unspecified,R60.9 - Edema, unspecified, **Date of Onset** :08/10/2024

Requested Investigations: 9, CONSULTATION GP,9, Consultation GP,82947-1, GRBS **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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 08-Jun-2024

Signature : **Date** : 08-Jun-2024