Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MUHAMMAD BAHIR**	**Service Date**	:**11-Jun-2024**
Card No	: **I022-029-114042580-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **MUHAMMAD BAHIR**	**Doctor's Name**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **30-08-2023** To **29-08-2024**		
Gender	: **Male**		
Date Of Birth	: **16-Jun-1990**		
Patient's Tel No	: **765697144**		

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 : 36.7 Bp :160 Pulse :65 Resp :21

Clinical Findings:

Diagnosis: L29.9 - Pruritus, unspecified,C84.00 - Mycosis fungoides, unspecified site, **Date of Onset** :11/11/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0078-140201-1451 - (FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN),0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM,

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

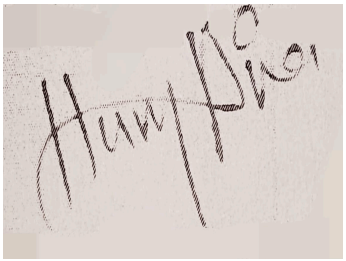
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 11-Jun-2024

Signature :



Date : 11-Jun-2024