Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ASHOK KUMAR PRASAD RAMJRAJ PRASAD**
Card No	**: I005-029-119061138-01**
Policy Holder	**: ASHOK KUMAR PRASAD RAMJRAJ PRASAD**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 25-08-2023** To **24-08-2024**
Gender	**: Male**
Date Of Birth	**: 02-Apr-1968**
Patient's Tel No	**: 05559012864**

Service Date :12-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 : co fever pain throat bodyache 3 days oe enlarge and inflamed tonsills chest is clear no added sounds restless **Duration:**

Vitals: Temp : 37 Bp :130 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified, **Date of Onset :**12/26/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, **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

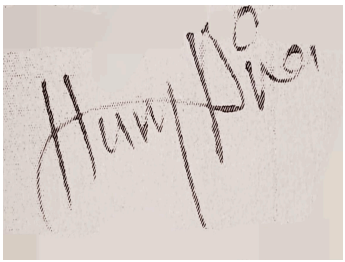
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 12-Jun-2024

Signature :



Date : 12-Jun-2024