Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SNEHA SURESH NAIR**
Card No	: **I040-029-120655348-01**
Policy Holder	: **SNEHA SURESH NAIR**
Payer Name	: **UNION INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **02-01-2024** To **01-01-2025**
Gender	: **Female**
Date Of Birth	: **22-Mar-2002**
Patient's Tel No	: **055980055**

Service Date :**12-Jun-2024**

Network : Green

Health Provider :**Irham Medical Center Arjan**

Direct Access SP - YES

Doctor's Name :**Enomen Goodluck**

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 : PAIN IN THROAT, COUGH AND PAIN IN THE LEFT EAR. **Duration :**

Vitals: Temp : 36.4 Bp :124 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,H65.02 - Acute serous otitis media, left ear,H92.02 - Otalgia, left ear, **Date of Onset** :12/29/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0070-120203-0651 - (GENTAMICIN : 0.1%) OINTMENT,0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 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 : 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 : 12-Jun-2024

Signature :

Date : 12-Jun-2024