Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **CHINNA NARAYANA THONTA ASHAIAH**	**Service Date**	:**19-Jun-2024**
Card No	: **I005-029-119066607-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **CHINNA NARAYANA THONTA ASHAIAH**	**Doctor's Name**	:**Humaira**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance:**	
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **25-08-2023** To **24-08-2024**		
Gender	: **Male**		
Date Of Birth	: **01-Jan-1989**		
Patient's Tel No	: **0569654144**		

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 : co weakness dehydration bodyache thirsty 15 june 2024 oe weakness iil looking pallor chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.2 Bp :119 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: E86.0 - Dehydration,R23.1 - Pallor,R52 - Pain, unspecified, **Date of Onset** :19/46/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,INJ014, INJ-NEUROBION VITAMIN B GROUPS,9, Consultation GP **Estimated Cost** :

Prescriptions: 1233-564801-1171 - (PYRIDOXINE (VITAMIN B6) : 2 MG) (VITAMIN B12 : 1 MG) (THIAMINE (VITAMIN B1) : 1.4 MG) (NIACINAMIDE : 18 MG) (BETACAROTENE : 400 MCG) (PHYTONADIONE (VITAMIN K1) : 30 MCG) (VITAMIN E : 10 IU) (BIOTIN : 100 MCG) (CHROMIUM : 40 MCG) (RIBOFLAVINE (VITAMIN B2) : 1.4 MG) (POTASSIUM : 40 MG) (ASCORBIC ACID (VITAMIN C) : 60 MG) (ZINC : 5 MG) (PHOSPHORUS : 125 MG) (SELENIUM : 30 MCG) (MAGNESIUM : 50 MG) (MOLYBDENUM : 50 MCG) 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

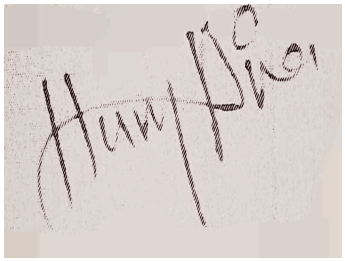
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 19-Jun-2024

Signature :



Date : 19-Jun-2024