Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MERCY NJERI . MUIRURI**	**Service Date**	**:21-Jun-2024**
Card No	**: I040-029-120879885-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: MERCY NJERI . MUIRURI**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**		
Validity	**: 02-01-2024** To **01-01-2025**	**Remarks**	**:**
Gender	**: Female**		
Date Of Birth	**: 19-Aug-1989**		
Patient's Tel No	**: 0557921056**		

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: missed period 7weeks. Usually menstruates for 5days in a regular cycle of 28days. **Duration:**

Vitals: Temp : 37.3 Bp :131 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: N91.2 - Amenorrhea, unspecified,R10.30 - Lower abdominal pain, unspecified, **Date of Onset** :21/02/2024

Estimated Cost :

Requested Investigations: 84704, HCG FREE BETACHAIN TEST,9, Consultation GP

Estimated Cost :

Prescriptions:

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.

Dr's Name : Enomen Goodluck

Stamp :

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

Signature :

Date : 21-Jun-2024

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.

Patient 's signature{Parent if minor} :

Date : 21-Jun-2024