Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **LAXMI NARAIN BRIJ RAJ PANDEY**	**Service Date**	:**23-Oct-2023**
Card No	: **I005-029-115888506-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **LAXMI NARAIN BRIJ RAJ PANDEY**	**Doctor's Name**	:**Sajid Sanaullah**
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	: **11-Aug-1965**		
Patient's Tel No	: **0555756569**		

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 : O/E Mild pallor, c/o Pain in right shoulder and low back pain for 5 days pain in calf muscles for 1 month tiredness, weakness one month Acidity, nausea **Duration:**

Vitals: Temp : 37 Bp :140 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M54.9 - Dorsalgia, unspecified,D64.9 - Anemia, unspecified,E55.9 - Vitamin D deficiency, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :23/41/2023

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 0069-106204-1171 - (MULTIVITAMINS : 600 MG) (MINERALS : 600 MG) TABLETS,0541-180401-0431 - (KETOPROFEN : 2.5%) GEL,1394-143701-1453 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN), **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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent : if minor}

Date : 23-Oct-2023

Signature :

Date : 23-Oct-2023