Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Sagar Baraku**
Card No	**: I005-029-117364305-01**
Policy Holder	**: Sagar Baraku**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 05-11-2022** To **04-11-2023**
Gender	**: Male**
Date Of Birth	**: 02-Feb-1990**
Patient's Tel No	**: 0505284056**

Service Date **:24-Oct-2023** **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 for one week. Coughing, chest pain and chest tightness since 5days. Difficulty breathing since this morning. There is no fever however. **Duration:**

Vitals: Temp : 37 Bp :110 Pulse :72 Resp :22

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J22 - Unspecified acute lower respiratory infection,R05 - Cough,R06.00 - Dyspnea, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :24/45/2023

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 1541-290302-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE),0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS, **Estimated Cost** :

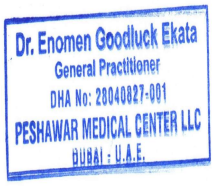
MEDICAL PRACTITIONER DECLARATION :

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.

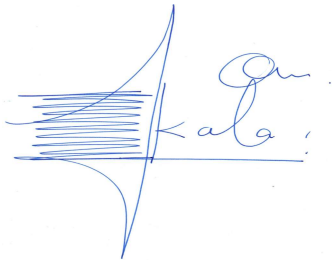
Dr's Name : Enomen Goodluck **Stamp :**



Patient 's signature{Parent if minor} :

Date : 24-Oct-2023

Signature :



Date : 24-Oct-2023