Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD ABU BAKR FAHAD FAHAD SHAHID**	**Service Date**	**:30-Oct-2023**	**Network**	: Green
Card No	: **I022-029-115696859-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MUHAMMAD ABU BAKR FAHAD FAHAD SHAHID**	**Doctor's Name**	**:Mohammadmahdi**		
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **17-10-2023** To **16-10-2024**				
Gender	: **Male**				
Date Of Birth	: **24-May-2009**				
Patient's Tel No	: **0588304625**				

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 : Has a strong family history of asthma but he has not been previously diagnosed of asthma., there is a history of hyperreactive airways in father side family, severe cough and sore throat for more than two weeks started on 15/10/2023 severe barking cough and wheezing started two days back **Duration:**

Vitals: Temp : 0 Bp :00 Pulse :78 Resp :24

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J01.21 - Acute recurrent ethmoidal sinusitis,J45.991 - Cough variant asthma,R06.2 - Wheezing, **Date of Onset** :30/43/2023

Requested Investigations: 10, Consultation Specialist,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0006-124513-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT **Estimated Cost** :

Prescriptions: 0252-148701-1171 - (LORATADINE : 10 MG) TABLETS,0139-116201-0391 - (AMOXICILLIN : 250 MG) (CLAVULANIC ACID : 125 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 :

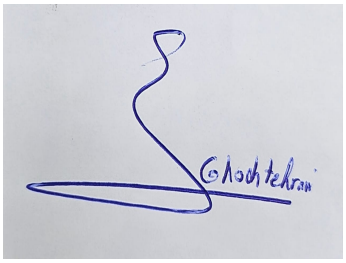
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Mohammadmahdi **Stamp :**

Patient 's signature{Parent if minor} :

Date : 30-Oct-2023

Signature :



Date : 30-Oct-2023