DirectThsclaimformBillingisnotan admissionClaim ofFormliability

Administrative Section

Policy number	13/xc/35519/0/98/W/2	Membership number	
Patient name	BILHA NYAMBURA WAMUCII	Provider name	Irham Medical Center Arjan
Date of treatment	31-Oct-2023	Patient Gender	○ Male ◉ Female

Medical Section

Type of visit ☐ **Outpatient** ☐ **Inpatient If** ☐ **Emergency** ☐ **Maternity** ☐ **Dental** ☐ **Optical**

If Pregnant: L.M.P. Date Nature of conception ○ **Natural** ○ **Assisted**

Chief complaint

Severe back pain, body pain, headache and fever.

symptoms started 3days ago.

History of present illness

Date	Doctor	Location	Quality	Severity	Duration	Timing	Context	Modifying Factor	Symptoms
No Previous Complaints Found									

Clinical findings/other conditions

Past medical history

Details of trauma - if applicable (where, when & how) ☐ **Work Related** ☐ **RTA Related** ☐ **Sports Related**

If yes ○ **Professional** ○ **Non-Professional**

Diagnosis

M54.5 - Low back pain, M79.10 - Myalgia, unspecified site, R51.9 - Headache, unspecified

Treatment plan, recommended medications, investigations, and/or procedures

Treatments: 85025, COMPLETE BLOOD COUNT (CBC), BLOOD,86140, C-REACTIVE PROTEIN (CRP),81001, ROUTINE EXAMINATION, URINE,9, GP Consultation

Prescription:2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,

Patient declaration

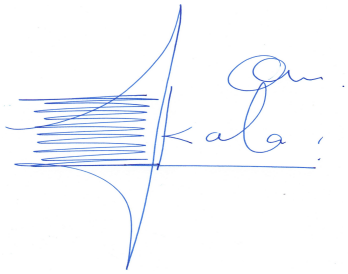
I hereby confirm that I am the patient/AXA card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/ information given above are to the best of my knowledge true and correct. I hereby consent to and fully authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates. I subrogate all my rights in relation to this claim and I fully authorize and give access to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates to audit, review and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original.

Signature Date:31-Oct-2023

Medical practitioner declaration

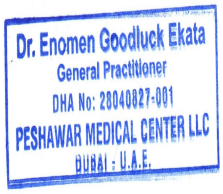
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Name



Signature Date:31-Oct-2023

Signature Date:31-Oct-2023



Stamp

WARNING:Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits / cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary.

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