Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SUSHIL POUDEL GOVINDA POUDEL**	**Service Date**	:**01-Nov-2023**
Card No	: **I040-029-119078847-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **SUSHIL POUDEL GOVINDA POUDEL**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2023** To **01-01-2024**		
Gender	: **Male**		
Date Of Birth	: **26-Nov-1996**		
Patient's Tel No	: **971563093585**		

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 : cough and headache **Duration :**

Vitals: Temp : 38.3 Bp :110 Pulse :100 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J20.9 - Acute bronchitis, unspecified,R05 - Cough,R52 - Pain, unspecified,R07.0 - Pain in throat,M54.5 - Low back pain, **Date of Onset** :01/16/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 1394-143701-1453 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),6960-116403-0061 - (AMOXICILLIN : 500 MG) CAPSULES,0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),1394-143701-1451 - (CELECOXIB : 200 MG) CAPSULES (HARD GELATIN),5944-174201-1451 - (OMEPRAZOLE : 20 MG) CAPSULES (HARD GELATIN),2626-106616-2002 - (PARACETAMOL : 665MG) MODIFIED RELEASE 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 : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 01-Nov-2023

Signature :  **Date** : 01-Nov-2023