Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **LIEZEL SUICO DESABILLE**	**Service Date**	:**04-Nov-2023**
Card No	: **I040-029-113719145-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **LIEZEL SUICO DESABILLE**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2023** To **01-01-2024**		
Gender	: **Female**		
Date Of Birth	: **19-Oct-1974**		
Patient's Tel No	: **0567312820**		

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 : C/o: Dry coughing since 1week. Also has pain in throat, and nasal congestion. Has upper abdominal pain and, bloating. Known diabetics. **Duration:**

Vitals: Temp : 37 Bp :128 Pulse :76 Resp :22

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,J22 - Unspecified acute lower respiratory infection,R05 - Cough,R10.10 - Upper abdominal pain, unspecified,R14.0 - Abdominal distension (gaseous), **Date of Onset** :04/20/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),0265-150407-1171 - (METOCLOPRAMIDE : 10 MG) TABLETS,0188-232402-0391 - (ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS,6603-947301-0061 - (ACTIVATED WOOD CHARCOAL : 250 MG) (SIMETHICONE : 80 MG) CAPSULES, **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.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 04-Nov-2023

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.

Patient 's signature{Parent if minor} :

Date : 04-Nov-2023