

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SYEDA HIBBA FAHAD
FAHAD SHAHID
Card No : I022-029-115696858-01
Policy Holder : SYEDA HIBBA FAHAD
FAHAD SHAHID

Payer Name : TAKAFUL EMARAT
TPA : E CARE - Green Network

Validity : 17-10-2023 To 16-10-2024

Gender : Female

Date Of Birth : 25-May-2007

Patient's Tel No : 0588304625

Service Date : 04-Nov-2023
Health Provider : Irham Medical Center Arjan
Doctor's Name : Enomen Goodluck

Network : Green
Direct Access SP - YES

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 : C/o: Dry cough for the past two days. Also has pain in throat and fever. She is a known asthmatic and currently uses montelukast 10mg daily. ENT: Inflamed and hypertrophied tonsils. Chest: mild rhonchi

Vitals: Temp : 37.2 Bp : 0 Pulse : 96 Resp : 24

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified, J45.30 - Mild persistent asthma, uncomplicated, R05 - Cough, R07.0 - Pain in throat, R09.81 - Nasal congestion, **Date of Onset** : 04/51/2023

Requested Investigations: 9, Consultation GP, 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT, 86140, C REACTIVE PROTEIN, 85652, SEDIMENTATION RATE RBC AUTOMATED, 94640, AIRWAY INHALATION TREATMENT, 0006-124513-2071, VENTOLIN NEBULES, 0188-135906-2441, PULMICORT, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE- (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, 0005-149902-1021, CLOFEN

Estimated Cost

Estimated Cost :

Prescriptions:

MEDICAL PRACTITIONER DECLARATION :

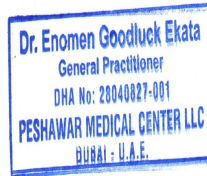
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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}



04-
Date : Nov-2023

Signature :

Date : 04-Nov-2023