

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MAQSOOD TAHIR ALI
 : TAHIR ALI ASGAR ALI
 Card No : I005-029-115888693-01
 Policy Holder : MAQSOOD TAHIR ALI
 : TAHIR ALI ASGAR ALI

Payer Name : DUBAI INSURANCE
 COMPANY

TPA : E CARE - Blue Network

Validity : 25-08-2023 To 24-08-2024

Gender : Male

Date Of Birth : 05-Aug-1966

Patient's Tel No : 0559278641

Service Date :06-Nov-2023

Network : Green

Health Provider :Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name :Sajid Sanaullah

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 gas-acidity, c/o pain knee since 2 weeks.

Duration :

Vitals:Temp : 36.3 Bp :140 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: M25.562 - Pain in left knee,K29.00 - Acute gastritis without bleeding,B35.3 - Tinea pedis,L08.9 - Local infection of the skin and subcutaneous tissue, unsp,A49.9 - Bacterial infection, unspecified,B35.9 - Dermatophytosis, unspecified, Date of Onset :06/32/2023

Requested Investigations: 9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION

Estimated :
Cost

Prescriptions: 0031-128401-0151 - (FUSIDIC ACID : 2%) CREAM,0031-109203-0151 - (TERBINAFINE (AS HCL) : 10 MG/G) CREAM,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,5944-174201-1451 - (OMEPRazole : 20 MG) CAPSULES (HARD GELATIN),4885-107902-0971 - (IBUPROFEN : 400 MG) SOFT GELATIN 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.

PATIENT'S DECLARATION :

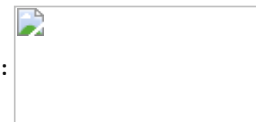
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Nov-2023

Signature :

Date : 06-Nov-2023