Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MAQSOOD TAHIR ALI TAHIR ALI ASGAR ALI**	**Service Date**	:**06-Nov-2023**
Card No	: **I005-029-115888693-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **MAQSOOD TAHIR ALI TAHIR ALI ASGAR ALI**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **25-08-2023** To **24-08-2024**		
Gender	: **Male**		
Date Of Birth	: **05-Aug-1966**		
Patient's Tel No	: **0559278641**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green

Direct Access SP - YES

☐ **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 : 06-Nov-2023

Signature :

Date : 06-Nov-2023