Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMAD ARIF ZAFAR MIR ZAFIRUL HASAN**	**Service Date**	**:07-Nov-2023**	**Network**	: Green
Card No	: **I005-029-115888672-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **MOHAMMAD ARIF ZAFAR MIR ZAFIRUL HASAN**	**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	: **29-Jul-1975**				
Patient's Tel No	: **971555033506**				

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 : fuc of right upper extremity pain, neuropathic? **Duration :**

Vitals:

Clinical Findings:

Diagnosis: M79.2 - Neuralgia and neuritis, unspecified,M54.2 - Cervicalgia,M79.601 - Pain in right arm,M79.621 - Pain in right upper arm, **Date of Onset** :07/32/2023

Estimated Cost:

Requested Investigations: 96374, THER/PROPH/DIAG INJ IV PUSH,2190-106618-1001, PARAFUSIV

Estimated Cost :

Prescriptions: 1162-106616-2001 - (PARACETAMOL : 665MG) MODIFIED RELEASE TABLETS,

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 :** 07-Nov-2023

Signature : **Date** : 07-Nov-2023