Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **RAJESH PRASAD DINA NATH PRASAD**	**Service Date**	:**11-Nov-2023**
Card No	: **I005-029-115888620-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **RAJESH PRASAD DINA NATH PRASAD**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-01-1900** To **24-08-2024**		
Gender	: **Male**		
Date Of Birth	: **30-Aug-1984**		
Patient's Tel No	: **971524807054**		

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 : Severe left knee swelling and pain in walking and sitting since ten days started **Duration:** 1/11/2023 history of vitamin D deficiency

Vitals: Temp : 36.6 Bp :139 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: M25.562 - Pain in left knee,E55.9 - Vitamin D deficiency, unspecified,M10.9 - Gout, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :11/44/2023

Requested Investigations: 0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN,84550, URIC ACID BLOOD,82310, CALCIUM TOTAL,84100, PHOSPHORUS INORGANIC,84075, PHOSPHATASE ALKALINE,9, Consultation GP **Estimated Cost** :

Prescriptions: 0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET,7070-149919-0431 - (DICLOFENAC SODIUM : 1 G/100G) GEL,4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS, **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 : 11-Nov-2023

Signature :

Date : 11-Nov-2023