

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : RAJESH PRASAD DINA
NATH PRASAD
Card No : I005-029-115888620-01
Policy Holder : RAJESH PRASAD DINA
NATH PRASAD

Service Date :11-Nov-2023
Health Provider :Irham Medical Center Arjan
Doctor's Name :Sajid Sanaullah

Network : Green
Direct Access SP - YES

Payer Name : DUBAI INSURANCE COMPANY

Co-Insurance:

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

TPA : E CARE - Blue Network

Validity : 01-01-1900 To 24-08-2024

Gender : Male

Date Of Birth : 30-Aug-1984

Patient's Tel No : 971524807054

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

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

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 :11/55/2023

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 DIRNTL 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 :

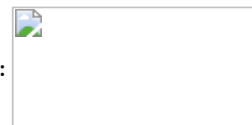
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient 's signature{Parent : if minor}



Date : Nov-2023

Signature :

Date : 11-Nov-2023