Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **FAHAD SHAHID SHAHID ANWAR**	**Service Date**	**:11-Nov-2023**
Card No	: **I022-029-114900499-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **FAHAD SHAHID SHAHID ANWAR**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **17-10-2023** To **16-10-2024**		
Gender	: **Male**		
Date Of Birth	: **05-Sep-1980**		
Patient's Tel No	: **0559305315**		

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 : C/o: Loose motion since 3days. Also feels slightly drowsy. Has 2 episodes today and about 3 episodes yesterday. There is no blood in stool, no mucus in stool and there is no fever. There is also no abdominal pain and there is no urinary symptoms. Has no significant past medical history. Exam: mild dehydration. **Duration:**

Vitals: Temp : 37 Bp :118 Pulse :74 Resp :20

Clinical Findings:

Diagnosis: K52.1 - Toxic gastroenteritis and colitis,R19.7 - Diarrhea, unspecified, **Date of Onset** :11/53/2023

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,80051, ELECTROLYTE PANEL,82565, CREATININE BLOOD,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA **Estimated Cost** :

Prescriptions: 1350-502201-1113 - (SPORE OF BACILLUS CLAUSI : 2 BILLION/5ML) SUSPENSION,0097-230603-2091 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) ORAL POWDER, **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.

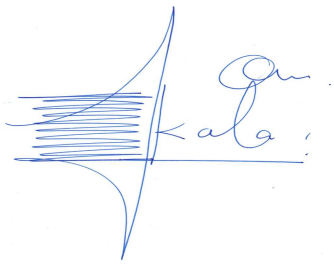
Dr's Name : Enomen Goodluck

Stamp :

Patient 's signature{Parent if minor} :

Date : 11-Nov-2023

Signature :



Date : 11-Nov-2023