Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **FAHAD SHAHID SHAHID ANWAR**	**Service Date**	**:12-Nov-2023**
Card No	: **I022-029-114900499-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **FAHAD SHAHID SHAHID ANWAR**	**Doctor's Name**	**:Sajid Sanaullah**
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 : Severe abdominal pain and diarrhea since 4 days started 8/11/2023 severe headache and drowsiness **Duration:**

Vitals: Temp : 36.7 Bp :104 Pulse :74 Resp :24

Clinical Findings:

Diagnosis: R19.7 - Diarrhea, unspecified,E86.0 - Dehydration,A03.8 - Other shigellosis, **Date of Onset** :12/32/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0042-136501-1171 - (HYOSCINE : 10 MG) TABLETS,0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN), **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 : 12-Nov-2023

Signature :

Date : 12-Nov-2023