Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NIDA FAHAD FAHAD SHAHID**	**Service Date**	:**19-Nov-2023**
Card No	: **022-029-114542689-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **NIDA FAHAD FAHAD SHAHID**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **17-10-2023** To **06-10-2024**		
Gender	: **Female**		
Date Of Birth	: **16-Sep-1984**		
Patient's Tel No	: **0588304625**		

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 : Diarrhea and vomiting since yesterday after eating Chinese food and abdominal pain started on 17/11/2023 **Duration:**

Vitals: Temp : 36.3 Bp :99 Pulse :84 Resp :21

Clinical Findings:

Diagnosis: R19.7 - Diarrhea, unspecified,E86.0 - Dehydration,K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified, **Date of Onset** :19/15/2023

Requested Investigations: 9, Consultation GP,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0005-242802-0781, PANTONIX 40MG I.V.,0005-150403-1021, PREMOSAN ,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA **Estimated Cost** :

Prescriptions: 0097-230603-0832 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0188-232401-0392 - (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS,0415-200001-1451 - (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 : 19-Nov-2023

Signature :

Date : 19-Nov-2023