Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **BIPIN BIHARI RAI**	**Service Date**	:**20-Nov-2023**
Card No	: **I022-029-119292566-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **BIPIN BIHARI RAI**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **01-11-2023** To **31-10-2024**		
Gender	: **Male**		
Date Of Birth	: **08-Jan-1963**		
Patient's Tel No	: **0505178195**		

Network : Green

Direct Access SP - YES

Co-Insurance :

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

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Chronic cardiac patient came for refill the medication **Duration :**

Vitals: Temp : 36.2 Bp :131 Pulse :59 Resp :21

Clinical Findings:

Diagnosis: I25.9 - Chronic ischemic heart disease, unspecified, **Date of Onset** : 20/25/2023

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-179203-0391 - (AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS,0096-124204-0341 - (ASPIRIN : 100 MG) ENTERIC COATED TABLETS,0030-244102-0391 - (CLOPIDOGREL : 300 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 : 20-Nov-2023

Signature :

Date : 20-Nov-2023