

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ASIF ZULKAR
Card No : I005-029-119174325-01
Policy Holder : ASIF ZULKAR
Payer Name : DUBAI INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 25-08-2023 To 24-08-2024
Gender : Male
Date Of Birth : 12-Jul-1997
Patient's Tel No : 0525783855

Service Date :24-Nov-2023
Health Provider :Irham Medical Center Arjan
Doctor's Name :Sajid Sanaullah

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 : sever cough and stridor from 16/11/2023

Duration :

Vitals:Temp : 35.8 Bp :116 Pulse :100 Resp :22

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J20.9 - Acute bronchitis, unspecified,

Date of Onset :24/16/2023

Requested Investigations: 9.01, Follow Up Consultation GP,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM

Estimated Cost :

Prescriptions: 0248-135501-1161 - (DEXTROMETHORPHAN : 125 MG/100ML) (DIPHENHYDRAMINE : 100 MG/100ML) (EPHEDRINE : 150 MG/100 ML) (GUAIFENESIN : 10 MG/ML) SYRUP,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) 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 :

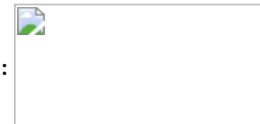
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent if minor} :



24-
Date : Nov-2023

Signature :

Date : 24-Nov-2023