Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **OSAID LAITH ESAM ODEH**	**Service Date**	:**02-Dec-2023**
Card No	: **I022-029-119971864-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **OSAID LAITH ESAM ODEH**	**Doctor's Name**	:**Mohammadmahdi**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **18-10-2023** To **17-10-2024**		
Gender	: **Male**		
Date Of Birth	: **07-Jul-2021**		
Patient's Tel No	: **0501296992**		

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 cough and wheezing and vomiting and wheezing since three days started on 29/11/2023 **Duration:**

Vitals: Temp : 36.2 Bp :0 Pulse :110 Resp :28

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,R11.2 - Nausea with vomiting, unspecified,J02.9 - Acute pharyngitis, unspecified,J45.991 - Cough variant asthma, **Date of Onset** :02/15/2023

Requested Investigations: 10, Consultation Specialist,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES **Estimated Cost** :

Prescriptions: 2066-395401-0081 - (MONTELUKAST (AS SODIUM) : 4 MG) CHEWABLE TABLETS,0188-135907-2441 - (BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION,0006-402803-2071 - (SALBUTAMOL(AS SULPHATE) : 1 MG/ML) NEBULIZING SOLUTION,0097-230603-0832 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0031-168202-1111 - (DOMPERIDONE : 1 MG/ML) SUSPENSION,0027-128801-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) LIQUID FOR SPRAY (NASAL),0207-142903-0851 - (CEFIXIME : 100 MG/5ML) POWDER FOR SUSPENSION, **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.

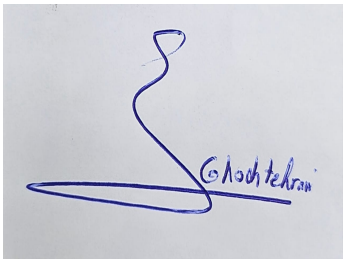
Dr's Name : Mohammadmahdi

Stamp :

Patient 's signature{Parent if minor} :

Date : 02-Dec-2023

Signature :



Date : 02-Dec-2023