Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ARYA SHIBU SHIBU CHANDRAN**	**Service Date**	:**08-Dec-2023**
Card No	: **I005-029-115775142-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **ARYA SHIBU SHIBU CHANDRAN**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **21-08-2023** To **20-08-2024**		
Gender	: **Female**		
Date Of Birth	: **06-May-1996**		
Patient's Tel No	: **0565760159**		

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 : High fever and body pain and severe cough since 5/12/2023 severe shivering **Duration:** since today

Vitals: Temp : 36.6 Bp :110 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: J02.8 - Acute pharyngitis due to other specified organisms,J20.9 - Acute bronchitis, unspecified,R68.83 - Chills (without fever), **Date of Onset** :08/39/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0006-124513-2071, VENTOLIN NEBULES,0188-135906-2441, PULMICORT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,4417-711201-0451 - (IBUPROFEN (AS L-ARGININE SALT) : 600 MG) GRANULES,0006-402804-2481 - (SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE),0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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} :

Date : 08-Dec-2023

Signature :

Date : 08-Dec-2023