

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ARYA SHIBU SHIBU
CHANDRAN
Card No : I005-029-115775142-01

Policy Holder : ARYA SHIBU SHIBU
CHANDRAN

Payer Name : DUBAI INSURANCE
COMPANY

TPA : E CARE - Green Network

Validity : 21-08-2023 To 20-08-
2024

Gender : Female

Date Of Birth : 06-May-1996

Patient's Tel No : 0565760159

Service Date :08-Dec-2023

Network : Green

Health Provider :Irham Medical Center Arjan

Direct Access SP - YES

Doctor's Name :Sajid Sanaullah

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

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 :

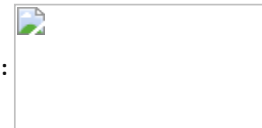
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2023

Signature :

Date : 08-Dec-2023