Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MUHAMMAD BAHIR**	**Service Date**	**:19-Dec-2023**
Card No	**: I022-029-114042580-01**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: MUHAMMAD BAHIR**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	**: TAKAFUL EMARAT**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**		
Validity	**: 30-08-2023 To 29-08-2024**		
Gender	**: Male**	**Remarks**	**:**
Date Of Birth	**: 16-Jun-1990**		
Patient's Tel No	**: 765697144**		

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 : **Duration :**

Vitals: Temp : 37 Bp :125 Pulse :80 Resp :0

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J21.9 - Acute bronchiolitis, unspecified,R06.2 - Wheezing,R68.83 - Chills (without fever), **Date of Onset** **:**19/32/2023

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV,0005-111805-1021, CHLOROHISTOL 10MG,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-124513-2071, VENTOLIN NEBULES,9, Consultation GP **Estimated Cost :**

Prescriptions: 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,0252-389802-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS,0097-116206-0391 - (AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 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 : 19-Dec-2023

Signature :

Date : 19-Dec-2023