Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ajij illyas**
Card No	**: I005-029-119206280-01**
Policy Holder	**: ajij illyas**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 26-07-2023** To **25-07-2024**
Gender	**: Male**
Date Of Birth	**: 05-Aug-1978**
Patient's Tel No	**: 0528896952**

Service Date **:18-Jan-2024** **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 : C/O FEVER,SORE THROAT AND RUNNY NOSE ALSO COMPLAINS OF BODYACHE SICE 2 DAYS ON EXAMINATION PATIENT HAS HYPREMIC THROAT AND CHEST CONGESTION **Duration:**

Vitals: Temp : 37.3 Bp :130 Pulse :92 Resp :22

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R52 - Pain, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J02.9 - Acute pharyngitis, unspecified, **Date of Onset** :18/11/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 1351-106305-0271 - (ASCORBIC ACID (VITAMIN C) : 1000 MG) EFFERVESCENT TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119805-1171 - (PREDNISOLONE : 5 MG) TABLETS,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0097-127405-0392 - (AZITHROMYCIN : 500 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 : 18-Jan-2024

Signature :

Date : 18-Jan-2024