Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAHUL THAKUR JOGINDER PAL**	**Service Date**	**:28-Jan-2024**	**Network**	: Green
Card No	: **I035-029-119648220-01**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **RAHUL THAKUR JOGINDER PAL**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**	**Remarks**	:		
Validity	: **18-11-2023** To **17-11-2024**				
Gender	: **Male**				
Date Of Birth	: **27-Jan-1999**				
Patient's Tel No	: **+919818890129**				

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 abdominal pain and vomiting sine yesterday and high blood pressure **Duration:** since 27/1/2024

Vitals: Temp : 37.3 Bp :156 Pulse :84 Resp :22

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,Z91.018 - Allergy to other foods,L23.9 - Allergic contact dermatitis, unspecified cause, **Date of Onset** :28/27/2024

Requested Investigations: 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,0005-150403-1021, PREMOSAN ,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0366-149801-0151 - (CLOBETASOL PROPIONATE : 0.05%) CREAM,0205-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0031-168201-0391 - (DOMPERIDONE : 10 MG) FILM COATED TABLETS,0669-242802-3261 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET, **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 :

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 28-Jan-2024

Signature :

Date : 28-Jan-2024