

Administrative

Patient Name : LIEZEL SUICO DESABILLE

Card No : I040-029-113719145-01

Policy Holder : LIEZEL SUICO DESABILLE

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Female

Date Of Birth : 19-Oct-1974

Patient's Tel No : 0567312820

Service Date :31-Jan-2024

Health Provider :Irham Medical Center Arjan

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 :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : C/o: Pain in throat and dry cough. with low grade fever. Chest: Clinically clear.

Duration:

Vitals:Temp : 36.4 Bp :121 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: J06.0 - Acute laryngopharyngitis,J20.9 - Acute bronchitis, unspecified,I10 - Essential (primary) hypertension,E78.5 - Hyperlipidemia, unspecified,

Date of Onset :31/58/2024

Requested Investigations: 9, Consultation GP,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0006-402803-2071, VENTOLIN NEBULES

Estimated Cost :

Prescriptions: 0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,0030-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0005-119803-1171 - (PREDNISOLONE : 20 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.

Dr's Name : Sajid Sanaullah

Stamp :

Dr. Sajid Sanaullah Khan

General Practitioner

DHA No: 05758224-001

PESHAWAR MEDICAL CENTER LLC

DUBAI - U.A.E.

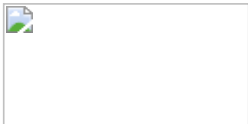
Signature :

Date : 31-Jan-2024

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.

Patient ‘s signature{Parent : if minor}



31-
Date : Jan-
2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appId=45849&patId=26009

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