Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ANISH PARIYAR**
Card No	**: I005-029-117534793-01**
Policy Holder	**: ANISH PARIYAR**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 23-11-2023** To **22-11-2024**
Gender	**: Male**
Date Of Birth	**: 26-Apr-2002**
Patient's Tel No	**: 0561509706**

Service Date :**28-Feb-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 : postular rashes all over on scalp but mainly in occipital region since 20 days **Duration:**

Vitals: Temp : 36.8 Bp :128 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: L08.9 - Local infection of the skin and subcutaneous tissue, unsp,L66.3 - Perifolliculitis capitis abscedens, **Date of Onset** :28/41/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-128701-1453 - (TETRACYCLINE : 250 MG) CAPSULES (HARD GELATIN),0005-142801-1452 - (CEPHALEXIN : 500 MG) CAPSULES (HARD GELATIN),0009-149102-0431 - (CLINDAMYCIN : 1%) GEL, **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 : 28-Feb-2024

Signature :

Date : 28-Feb-2024