Aafiya
Managing your care process

MEDICAL CLAIM FORM

Provider Name: Irham Medical Center Arjan	Patient Name: MOHAMMAD KHALIQUZZAMAN SIDDIQUI MUHAMMAD NASIM SIDDIQUI	
Insurance Company: AAFIYA MEDICAL BILLING SERVICES LLC	Patient Contact No: 507286355	File No: 38184
Company Name:	Member ID: 1380561	
Date of Treatment : 28-Feb-2024	Date of Birth: 31-Dec-1954	Gender : Male

Chief Complaints : C/O WEAKNESS ,PAIN IN LOWER BACK AND WEIGHT LOSS ,3KG IN PAST 15 DAYS

Referral(if needed):

Clinical Findings BP: 148 TEMP: 36.8 HR: 82 RR: 22

Diagnosis: Essential (primary) hypertension, Weakness, Dehydration, Low back pain	Diagnosis Code:I10, R53.1, E86.0, M54.5	Date of Onset 28-Feb-2024

PEC/CHRONIC ○ CONGENITAL ○ MATERNITY ○ DENTAL ○ OPTICAL ○ WORK RELATED ○ OTHERS ○

Treatment Plan: 9, GP Consultation,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,96360, Intravenous infusion, hydration; initial, 31 minutes to 1 hour,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96374, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,96361, Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)

Requested Investigations :	Estimated Cost :

Prescription

Medicine	Dose	Duration
(PERINDOPRIL : 5 MG) TABLETS	TABLETS (30S, BOTTLE)	30
(ACECLOFENAC : 100 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7

Estimated Cost :

MEDICAL PRACTIONER 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: 28-Feb-2024

PATIENT'S DECLARATION:

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining Insurance benifits.

Patient's Signature(Parent If Minor): Date : 28-Feb-2024

Aafiya Medical Billing Services reserve its right during the Agreement period with the service provider, survey and audit the service provider's operations with respect to its performance of services, the patient visit details and claims.

24/7 Claims Centre

Helpline: 9714263 0666 | Tel: 971 4 283 8116 | Fax: 971 4 283 8115 | Email: claims@aafiya.ae | Website: www.aafiya.ae