

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ADIN NAIDOO
Card No : I022-029-119250085-01
Policy Holder : ADIN NAIDOO
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 16-10-2023 To 15-10-2024
Gender : Male
Date Of Birth : 10-Jul-2015
Patient's Tel No : 0557230486

Service Date :06-Mar-2024
Health Provider :Irham Medical Center Arjan
Doctor's Name :Sajid Sanaullah

Network : Green
Direct Access SP - YES

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 FLU, COUGH, HEADACHE AND FEVER SINCE 2 DAYS Duration :

Vitals: Temp : 36 Bp : 0 Pulse : 92 Resp : 26

Clinical Findings:

Diagnosis: J00 - Acute nasopharyngitis [common cold], R51.9 - Headache, unspecified, R05 - Cough, Date of Onset : 06/40/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1086-123702-1381 - (CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL), 0252-107904-1111 - (IBUPROFEN : 100 MG/5ML) SUSPENSION, 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 :

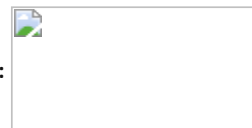
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah

Stamp :



Patient's signature {Parent : if minor}



Date : Mar-2024

Signature :

Date : 06-Mar-2024