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** **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 : 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 : 06-Mar-2024

Signature :

Date : 06-Mar-2024