Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Mansoor Ali Yameen Ali**
Card No	**: I040-029-113719090-01**
Policy Holder	**: Mansoor Ali Yameen Ali**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 25-Sep-1985**
Patient's Tel No	**: 0502245460**

Service Date :**22-Mar-2024** **Network** : Green

Health Provider :**Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name :**Enomen Goodluck**

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 : Fever since 2 days. Weakness and unable to go to work. Had sorethroat 2days ago which has now resolved, still has nasal discharge. Known hypertensive and diabetic. **Duration:**

Vitals: Temp : 36.6 Bp :135 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: J01.00 - Acute maxillary sinusitis, unspecified,I10 - Essential (primary) hypertension,Z79.899 - Other long term (current) drug therapy,R50.9 - Fever, unspecified, **Date of Onset** :22/46/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0069-108001-0111 - (IBUPROFEN : 200 MG) (PSEUDOEPHEDRINE : 30 MG) COATED TABLETS,0688-211505-0391 - (FENOFIBRATE : 145 MG) FILM COATED TABLETS,0252-155401-0391 - (LOSARTAN POTASSIUM : 50 MG) FILM COATED 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 : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Signature :

Date : 22-Mar-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}

Date : 22-Mar-2024