Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NARESH GENDA LAL**
Card No	**: I035-029-118743875-01**
Policy Holder	**: NARESH GENDA LAL**
Payer Name	**: SALAMA – Islamic Arab Insurance Company**
TPA	**: E CARE - Blue Network**
Validity	**: 23-11-2023** To **22-11-2024**
Gender	**: Male**
Date Of Birth	**: 03-Aug-1993**
Patient's Tel No	**: 0569644103**

Service Date :28-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 : C/o: pain in the anus on defecation since 3hours. There is no bleeding **Duration :**

Vitals: Temp : 36.8 Bp :126 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: K60.0 - Acute anal fissure,K64.9 - Unspecified hemorrhoids,K62.89 - Other specified diseases of anus and rectum,K21.00 - Gastro-esophageal reflux dis with esophagitis, without bleed, **Date of Onset** :28/51/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0137-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS,0135-223401-1171 - (NAPROXEN : 500 MG) TABLETS,0071-158501-0391 - (HESPERIDIN : 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION) : 450 MG) FILM COATED TABLETS,0027-149903-2231 - (DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES, **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** : 28-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 :** 28-Mar-2024