Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: MUHAMMAD BAHIR	**Service Date**	:02-Apr-2024
Card No	: I022-029-114042580-01	**Health Provider**	:Irham Medical Center Arjan
Policy Holder	: MUHAMMAD BAHIR	**Doctor's Name**	:Enomen Goodluck
Payer Name	: TAKAFUL EMARAT	**Co-Insurance**	:
TPA	: E CARE - Blue Network		
Validity	: 30-08-2023 To 29-08-2024		
Gender	: Male	**Remarks**	:
Date Of Birth	: 16-Jun-1990		
Patient's Tel No	: 765697144		

Network : Green

Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Itchy and watery eyes. Also mucopurulent discharge and stickiness in the mornings. **Duration:**

Vitals:

Clinical Findings:

Diagnosis: H10.13 - Acute atopic conjunctivitis, bilateral,H10.89 - Other conjunctivitis,L29.8 - Other pruritus, **Date of Onset :**02/54/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 1111-183202-0391 - (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS,

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 : 02-Apr-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 : 02-Apr-2024