Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ANA MUNTEANU**	**Service Date**	**:13-Apr-2024**
Card No	**: I005-029-116406792-03**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: ANA MUNTEANU**	**Doctor's Name**	**:Enomen Goodluck**
Payer Name	**: DUBAI INSURANCE COMPANY**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Validity**	**: 15-08-2023 To 14-08-2024**
Gender	**: Female**	**Remarks**	**:**
Date Of Birth	**: 19-Dec-1984**		
Patient's Tel No	**: 0502281594**		

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 : Cough since one week, block nostrils with running nose and low grade fever. **Duration:**
There is no chest pain, not a known asthmatic and not diabetic and not hypertensive.

Vitals: Temp : 37.5 Bp :98 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J22 - Unspecified acute lower respiratory infection,J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :13/11/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-116801-2481 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE),0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,

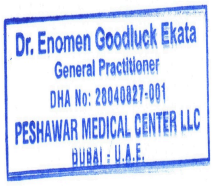
Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

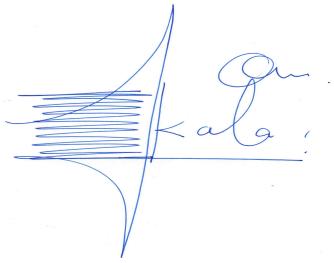
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :



Signature :



Date : 13-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 : 13-Apr-2024