Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Jeet Bahadur**	**Service Date**	:**18-Apr-2024**
Card No	: **I005-029-120677326-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **Jeet Bahadur**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **24-10-2023** To **23-10-2024**		
Gender	: **Male**		
Date Of Birth	: **20-Apr-1998**		
Patient's Tel No	: **0568431683**		

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 : Swelling on the right side of the cheek for the past 15days. Said to have been initially firm but now cystic. associated low grade intermittent fever. Exam: markedly tender and hyperemic cystic swelling. It is multiloculated and large, measuring 10cm by 16cm. **Duration:**

Vitals: Temp : 37.1 Bp :120 Pulse :77 Resp :18

Clinical Findings:

Diagnosis: L02.01 - Cutaneous abscess of face,R50.81 - Fever presenting with conditions classified elsewhere, **Date of Onset :**18/52/2024

Requested Investigations: 10061, INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0802, CEFTRIAXONE-TABUK IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-142201-2401 - (DICLOFENAC POTASSIUM : 50 MG) SUGAR COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, **Estimated Cost** :

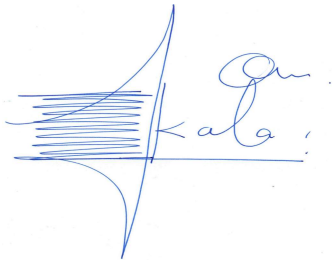
MEDICAL PRACTITIONER DECLARATION :

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 : 18-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 : 18-Apr-2024