

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SAMEH ELSAYED SALAMA
Card No : I020-029-118352043-02
Policy Holder : SAMEH ELSAYED SALAMA
Payer Name : AL-BUHAIRA NATIONAL INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 01-02-2024 To 31-01-2025
Gender : Male
Date Of Birth : 15-Jun-1985
Patient's Tel No : 971 56 165 6218

Service Date:20-Apr-2024
Health Provider :Irham Medical Center Arjan
Doctor's Name :Enomen Goodluck
Co-Insurance :

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

Network : Green
Direct Access SP - YES

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : Rashes on the trunk and thighs since 3 days duration. it is non-itchy. Has no other symptoms and there is no flu. Exam: multiple hyperemic papules densely distributed on the trunk.

Vitals:Temp : 37 Bp :137 Pulse :85 Resp :18

Clinical Findings:

Diagnosis: L30.9 - Dermatitis, unspecified,A88.0 - Enteroviral exanthematous fever [Boston exanthem], **Date of Onset :**20/14/2024

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

Estimated Cost :

Prescriptions: 5363-148701-1173 - (LORATADINE : 10 MG) TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0006-149803-0151 - (CLOBETASOL PROPIONATE : 0.5 MG/G) CREAM,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

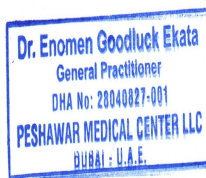
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

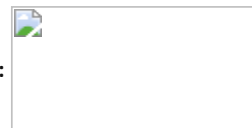
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient's signature{Parent : if minor}



Date : 20-Apr-2024

Signature :

Date : 20-Apr-2024