## Administrative MEDICAL CLAIM FORM Claim Ref:

| | |
|---|---|
| **Patient Name** | **: SAMEH ELSAYED SALAMA YOUNES** |
| **Card No** | **: I020-029-118352043-02** |
| **Policy Holder** | **: SAMEH ELSAYED SALAMA YOUNES** |
| **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** **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 :** 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. **Duration:**

**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.

**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** : 20-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** : 20-Apr-2024