Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JAI PRAKASH BRIJNATH YADAV**
Card No	**: I035-029-115704844-01**
Policy Holder	**: JAI PRAKASH BRIJNATH YADAV**
Payer Name	**: SALAMA – Islamic Arab Insurance Company**
TPA	**: E CARE - Blue Network**
Validity	**: 07-08-2023** To **06-08-2024**
Gender	**: Male**
Date Of Birth	**: 01-Oct-1970**
Patient's Tel No	**: 0527934507**

Service Date :27-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 : Frequent loose stool since this morning, Said to have began after taking some pain medicines indicated for tooth ache. There is no abdominal pain. **Duration:**

Vitals: Temp : 36.6 Bp :146 Pulse :76 Resp :22

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R19.7 - Diarrhea, unspecified, **Date of Onset :**27/54/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0097-230603-2091 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) ORAL POWDER,0137-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS,0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN), **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 :** 27-Apr-2024

Signature : **Date :** 27-Apr-2024