Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MAHROSH ZAHID**
Card No	**: I022-029-120554468-01**
Policy Holder	**: MAHROSH ZAHID**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 08-03-2024** To **07-03-2025**
Gender	**: Female**
Date Of Birth	**: 12-Jul-2020**
Patient's Tel No	**: 0544047084**

Service Date **:01-May-2024** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Humaira**

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 : co fever cough body ache oe chest is congested too much coughing irretable **Duration:**

Vitals: Temp : 39.1 Bp :0 Pulse :102 Resp :24

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough, **Date of Onset :**01/59/2024

Requested Investigations: 9, Consultation GP,8787, Voltaren Suppository,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: **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 : Humaira **Stamp :** 

Patient 's signature{Parent if minor} :  **Date :** 01-May-2024

Signature :  **Date** : 01-May-2024