Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: VANESSA DUPITAS**
Card No	**: I011-029-116777419-01**
Policy Holder	**: VANESSA DUPITAS**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 20-05-2023** To **19-05-2024**
Gender	**: Female**
Date Of Birth	**: 14-Sep-1994**
Patient's Tel No	**: 0551085062**

Service Date :06-Sep-2023 **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 : for follow up. CBC report shows moderate anemia. **Duration :**

Vitals: Temp : 37 Bp :120 Pulse :90 Resp :24

Clinical Findings:

Diagnosis: D50.9 - Iron deficiency anemia, unspecified,D53.9 - Nutritional anemia, unspecified,R23.1 - Pallor, **Date of Onset :**06/19/2023

Estimated Cost :

Requested Investigations: 83540, IRON,83550, IRON BINDING CAPACITY

Prescriptions: 0252-182201-0081 - (FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE 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.

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 :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 20040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 06-Sep-2023

Signature :

Date : 06-Sep-2023