Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : **RAMY ROMEL DEEB**
Card No : **I011-029-120730122-01**
Policy Holder : **RAMY ROMEL DEEB**
Payer Name : **AL SAGR NATIONAL INSURANCE COMPANY**
TPA : **E CARE - Blue Network**
Validity : **10-02-2024** To **09-02-2025**
Gender : **Male**
Date Of Birth : **18-Sep-1992**
Patient's Tel No : **0585419924**

Service Date :**03-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 lower back pain not releaved any medications oe stretched back muscle tender and rigid **Duration:**

Vitals: Temp : 36.5 Bp :136 Pulse :69 Resp :22

Clinical Findings:

Diagnosis: S39.012A - Strain of muscle, fascia and tendon of lower back, init,M54.18 - Radiculopathy, sacral and sacrococcygeal region, **Date of Onset** :03/43/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **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 : Humaira

Stamp :

Signature :

Date : 03-May-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 : 03-May-2024